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ABSTRACT

This teachers manual provides three instructional units (Chemical Dependency, A Disease; The Family; and Intervention and Recovery) for chemical dependency education at the high school level. The history, objectives, and teaching philosophy of the program are discussed briefly, and a course syllabus outline and audiovisual aids list by section are provided. The format for each of the three sections consists of a teacher guide with specific directions for each day of instruction; activities and readings including student handouts; and teacher resource materials. Section 3 also includes student and teacher unit evaluation sheets. A fourth section provides additional resource material, e.g., lists of films available from the school library, supplemental activities and projects, a speakers list with addresses and phone numbers, and fact sheets on marijuana and alcohol. Although some of the material is geographically specific (e.g., a map to Bryan High) the guide would be useful to anyone wishing to implement chemical dependency instruction at the high school level. (MCF)

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Chemical Dependency Unit

One Aspect of the Program for Student Assistance of Bryan Sr. High School

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Teacher Manual

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CHEMICAL DEPENDENCY UNIT

PART I

Chemical Dependency, A Disease

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With appreciation to the following who contributed to this unit:

Jean Kelley, *OACA staff member*

Nancy Johnson, *Chemical dependency counselor and former Bryan High Teacher*

Marcia Abbott, *Assistant Principal, Bryan High*

Sharon Franzen, *Counselor, Bryan High*

Omaha Area Council on Alcoholism (OACA)

Bryan High Student Assistance Committee

Many of the readings and exercises contained in this unit were taken from:

The Bare Facts on Alcoholism, printed by the Omaha Area Council on Alcoholism

Alcohol Use and Abuse: Awareness in Action, A Teacher's Guide for Alcohol Education, prepared by the Nebraska State Department of Education

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Chemical Dependency Unit
Teacher Manual
Table of Contents

History, Objectives, Teaching Philosophy . . . . . i, ii
Syllabus . . . . . iii, iv
Audio-Visual Aids iv
Resource People iv

Part I - Chemical Dependency, A Disease

Contents
Teacher Guide . . . . . I, 1-2
Unit Activities - Readings . . . . . I, 3-31
Teacher Resource Materials . . . . . I, 32-50

Part II - The Family

Contents
Teacher Guide . . . . . II, 1-2
Unit Activities - Readings . . . . . II, 3-30
Teacher Resource Materials . . . . . II, 31-53

Part III - Intervention & Recovery

Contents
Teacher Guide . . . . . III, 1
Unit Activities - Readings . . . . . III, 2-16
Teacher Resource Materials . . . . . III, 17-29
Student Evaluation of Unit . . . . . III, 30
Teacher Evaluation of Unit . . . . . III, 31

Part IV - Additional Resource Material

Contents
Additional Films . . . . . IV, 1
Additional Activities . . . . . IV, 2-3
Speakers' List and Guidelines . . . . . IV, 4-6
Readings . . . . . IV, 7-55

Part I, Chemical Dependency, A Disease

Teacher Guide . . . . . I, 1-2
Pre-test . . . . . I, 3
Pre-test Answer Key . . . . . I, 4
Fact Sheet on Alcoholism . . . . . I, 5-7
Worksheet . . . . . I, 8
Alcohol Attitudes . . . . . I, 9
Old Myths and New Facts About Alcoholism . . . . . I, 10-17
High Risk Groups Activity Sheet . . . . . I, 19
Jellnick's Chart of Dependency & Recovery . . . . . I, 20
Chemical Dependency Stages - Summary . . . . . I, 21
Early Warning Signs of Alcoholism . . . . . I, 22-29
Student Discussion Questions . . . . . I, 30
Problem vs. Non-Problem Activity . . . . . I, 31
Teacher Resource Material
- Definition and Introduction to Causes . . . . . I, 32-35
- Chemical Dependency Life Wheel . . . . . I, 36
- The Problem of Alcoholism . . . . . I, 37-44
- High Risk Groups . . . . . I, 45
- Warning Signs . . . . . I, 46-50

Chemical Dependency Unit

HISTORY

In the spring of 1979, the staff at Bryan Senior High School, under the direction of Dr. John McQuinn, committed itself to realistically addressing the problems of student chemical abuse and chemical dependency. A committee identified three areas of importance: education of the staff, curriculum development and the design of a student assistance program.

The committee felt that it was essential to accurately inform and educate the staff as the first step in creating a viable program. Teachers, counselors, administrators, several parents and students participated in a seven week in-service workshop on alcoholism and chemical dependency conducted by the Omaha Area Council on Alcoholism. The workshop helped participants examine their own existing attitudes and provided factual information regarding chemical dependency. In addition, the committee consulted numerous other community resources in order to insure a broad base of knowledge.

The next step was to evaluate existing building curricula and to research other available drug education materials. The committee wished to comply with state law No. 79-1270 which states that "provisions shall be made by the proper local school authorities for instructing the pupils in all schools in a comprehensive health education program which shall include instruction as to the physiological, psychological, and sociological aspects of drug use, misuse and abuse . . ."

OBJECTIVES

Working closely with representatives of the Omaha Area Council on Alcoholism and referring to the information gleaned from research studies, a unit was devised with the following objectives in mind:

1. To comply with the Nebraska State Law No. 79-1270.
2. To introduce the disease concept of alcoholism as recognized by the American Medical Association.
3. To teach the facts and dispel the myths about chemical dependency.
4. To improve the students' self-concept.
5. To introduce students to effective coping skills for life situations.
6. To introduce students to decision-making skills.
7. To teach effective methods of coping with chemical dependency.
8. To make students aware of the community resources for the chemically dependent person and/or the family members.

TEACHING PHILOSOPHY

Although most of this information is geared toward "alcoholism" the dynamics of the disease (especially with the family) may be applied where there is a problem with any chemical or drug. Therefore, the terms "alcoholism" and "chemical dependency" should be used interchangeably.

TEACHING PHILOSOPHY (Continued)

In our opinion, the physiological effects of specific drugs are less important than looking at the broader issues that involve all areas of the person's life (not just the physical aspects). Too often drug programs that emphasize the specific results of using drugs simply teach kids to be more efficient users, or to change to another drug. Sometimes too, if the teacher's information conflicts with the students' working knowledge, the teacher's credibility is lost.

Please use the terms "he" and "she" interchangeably in class discussion when referring to the alcoholic or chemically dependent person. Often the public stereotype says women cannot be alcoholics (nor can people under the age of 40), this is not true.

To be most effective, it is essential that the teacher has first examined his/her existing attitudes toward the alcoholic or chemically dependent person. Often the teacher conveys reliable information in class, but with an attitude that discounts that information. Often staff may find themselves with an attitude of moral superiority to the chemically dependent person who is viewed as "weak." At the very least, such an attitude may prevent some students from discussing a problem or potential problem with a staff member because the student does not want to be viewed as a "weakling." Such an attitude will significantly interfere with a teacher's use of this curriculum, which addressed alcoholism and chemical dependency as a comprehensive health problem.

Teachers need to be aware that some students may be very defensive during this unit, either because they have a problem themselves or someone close to them does. Others may become unusually silent or withdrawn. With students who are argumentative or belligerent, especially when the early warning signs are discussed (particularly blackouts), it is usually effective to mention in class that denial or the inability to discuss the problem is characteristic of chemical dependency. This should not be said in a pointed or sarcastic way, merely given as information.

BRYAN HIGH SCHOOL
STUDENT ASSISTANCE COMMITTEE

Chemical Dependency Unit
Syllabus

Part I – Introduction

Day 1 – Reasons for unit.
Pre-test.
Discuss attitudes about alcoholics.
Discuss the concept of stereotypes and relate to alcoholics.
Assign reading of facts about alcoholism.

Day 2 – Discuss alcohol attitudes.
Lecture on alcoholism, disease concept, sources of alcoholism.

Day 3 – Discuss high risk groups.
Lecture on Jellnick's chart of progressive stages of dependency and addiction.
Assign reading on early warning signs and stages of chemical dependency.

Day 4 – Complete lecture on Jellnick's chart.
Discuss early warning signs and stages of chemical dependency.
Discuss Bryan High student use of alcohol.
By discussing specific situations, determine if students can identify problem chemical usage.

Day 5 – Review the early warning signs.
Show film, "Feeling No Pain" and discuss.

Part II – The Family

Day 1 – Discuss decision-making skills model.
Use model to resolve specific problems.
Assign worksheet on making responsible decisions.

Day 2 – Continue discussion of responsible decision-making.
Relate to student recreational activities.
Lecture on early warning signs for the family.
Discuss the 5 major survival defense mechanisms of family members.
Assign reading about the family of the alcoholic and completion of worksheet on recreational activities.

Day 3 – Continue discussion of use of recreation time.
Continue discussion of family problems caused by chemical dependency.
Show film "The First Step" and discuss.

Day 4 – Show videotape "Stoned" and discuss.
Discuss self-concept.
Assign completion of self-esteem questionnaire.

Day 5 – Tell students how to score questionnaire.
Encourage students to set a personal goal of raising self-esteem.
Lecture on Fetal Alcohol Syndrome.
Show videotape "Mama Boozes, Baby Loses" and discuss.

Part III – Intervention and Recovery

Day 1 – Lecture on Jellnick's chart of progressive stages of recovery.
Assign reading about intervention and recovery from alcoholism.

Day 2 – Discuss intervention techniques, community resources and recovery.
Review for final test on unit.
Assign study for final test.

Day 3 – Answer any questions on unit.
Give final exam.
Correct in class and discuss.
Give students a questionnaire to complete in private to determine if they have a problem with chemical abuse.

Day 4 – Speakers' panel of recovering chemically dependent young people.

Audio-Visual Aids and Resource People Used in this Unit

Part I – Introduction

Film "Feeling No Pain" (30 minutes). Available on loan from Omaha Area Council on Alcoholism, 2222 California Street, 345-4080. Reserve well in advance.

Part II – The Family

Film "The First Step" (30 minutes). Available on loan from OPS Film Library. Reserve well in advance.
Videotape "Stoned" (40 minutes). Available at Bryan High library.
Videotape "Mama Boozes, Baby Loses" (10 minutes). Available at Bryan High library.

Part III – Intervention and Recovery

Panel of Recovering Chemically Dependent Young People planned for last day of unit. See list of speakers available in Teachers' Resource Material. Contact well in advance. Confirm with letter, map to Bryan High, and include Speakers' Guidelines. (See Teacher Resource Materials.)

Part I – Chemical Dependency, A Disease

Teacher Guide

TEACHER PREPARATION - Read Pp. I,32 – 50 of this section. Additional relevant information available in the Teachers' Resource Section of this manual.

Day 1 – A. Introduce Unit – why taught – why emphasis on alcohol.

B. Distribute pre-test on alcoholism (P. I,3-Student Handout):correct in class (see P. I,4) and then collect.

C. Discuss attitudes – write the word alcoholic on the board. Ask students to spend about 5 minutes writing a description of the visual image they get when they hear the word alcoholic. Encourage them to be as detailed as possible.

D. Discuss the concept of stereotype.
Many students will have written a description of similar stereotypes, i.e. skidrow bum, burned out teenager, rich old lady, business man, etc. List the stereotypes on the board. Ask the class to flesh out the stereotypes: add details concerning what the person drinks, when, where, with whom, family background, job, usage of other drugs, etc. Allow students to verbalize their existing attitudes. Do not "correct" them at this point.

E. Assign: reading from "Fact Sheet on Alcoholism" (P. I,5-7) and complete worksheet. (P. I,8-Student Handout).

Day 2 – A. Using the sheet "Alcohol Attitudes", (P. I,9) ask the class to rank the characters (each student by himself) and then discuss the ranking as a group.

B. Lecture and ask students to take notes. (This material in "Definition and Introduction to Causes" (P. I,32-37).

1. What is alcoholism?
2. What are 3 traditional viewpoints?
3. What is the evidence supporting the disease concept?
4. Define alcoholic.

C. Assign additional reading from "Old Myths & New Facts . . ." (P. I,10-17). Write a one-sentence summary of each section.

Day 3 – A. Discuss High Risk Groups (see P. I,45 & P. I,19).

B. Discuss Responsible-Irresponsible Exercise (P. II,6-8).

C. Lecture and ask students to take notes on Jellnick's Chart. Use only left side at this time (P. I,20). Use many examples to clarify points.

D. Assign reading of "Stages of Chemical Dependency" (P. I,21) and "Early Warning Signs." (P. I,22-29). Prepare for a quiz on the readings.

Day 4 – A. Quiz – List the Early Warning Signs of Chemical Dependency.

B. Complete lecture on Jellnick's Chart, left side.

C. Discuss readings assigned to students – "Early Warning Signs" and "Stages of Chemical Dependence" - and ask students to give more examples of early warning signs.

D. Use "Student Discussion Questions." (P. I,30)

E. Read each situation on "Problem vs Non-Problem" sheet (P. I,31) and discuss in class to determine if class can identify problem chemical usage.

Day 5 – A. Review the Early Warning Signs and Stages of Chemical Dependency. Distribute Early Warning Signs (Student Handout). Alternative Activities follow. Choice based on film availability.

B. Show film "Feeling No Pain." (30 minutes)

C. Discuss film. This is the story of a high school senior's progressive deterioration through his senior year. The students should be able to identify the clearly evident "Early Warning Signs of Chemical Dependency."

OR

B. Show the film "All Bottled Up." (10 minutes)

C. Discuss the film which gives a very realistic portrayal, in color animation, of family life disturbed by alcoholism. Coping mechanisms are presented.

Chemical Dependency Pre-Test

Give two reasons why alcoholism is considered a disease.

1.

2.

3. Define "alcoholic".

True or False. If the answer is true, put a + in the blank; if the answer is false, put a 0 in the blank.

_____ 4. All alcoholics drink on a daily basis.

_____ 5. Tremors and early morning drinking usually indicate that the alcoholic has become physically addicted to alcohol.

_____ 6. Most alcoholics are on Skid Row.

_____ 7. About one out of every ten people who drink becomes alcoholic.

_____ 8. All alcoholics become alcoholic the first time they drink alcohol.

_____ 9. People become alcoholic because they don't have any willpower.

_____10. People under 21 are too young to become alcoholic.

_____11. Alcoholics are people whose drinking causes repeated problems in any area of their lives.

List four of the early warning signs of alcoholism.

12.

13.

14.

15.

Chemical Dependency Pre-Test Answer Key

1. There are symptoms.
2. The symptoms are progressive. (Or, it can be diagnosed, or it is treatable.)
3. An alcoholic is a person whose drinking causes repeated problems in any area of his/her life.
4. 0
5. +
6. 0 - This is a stereotype. Many alcoholics have jobs and families.
7. +
8. 0
9. 0 - Alcoholism is a disease.
10. 0
11. +

12-15. (See P. I,22-29 for Early Warning Signs.)

FACT SHEET ON ALCOHOLISM

Alcoholism is the most neglected health problem in the United States today. It ranks with cancer and heart disease as a major threat to the nation's health. Deaths from cirrhosis of the liver, one of the many known physical conditions which are part of alcoholism, have increased 67% in the last 20 years.

Approximately 100 million persons over the age of 15 in this country are consumers of alcohol. Of these, there are an estimated 10 million suffering from the disease of alcoholism. The number of known women alcoholics has doubled since World War II. Less than 3% of the people with alcoholism are found on Skid Row.

Between six and 10% of employees are alcoholic. The total cost to the nation is $32 billion a year due to absenteeism, health and welfare services, property damage and medical expenses. Lost work time alone, because of alcoholism, has been computed at 9.35 billion dollars annually. The human loss to individuals, families and communities is incalculable.

Of all fatal accidents occurring on the roads today, 50% involve alcohol. Two-thirds of these fatal accidents involve an alcoholic. Fifty-three percent of fire deaths, 45% of drownings, 22% of home accidents, 36% of pedestrian accidents, 55% of arrests are linked to misuse of alcohol. Alcoholism accounts for 37.4% of admissions to state and county mental hospitals.

Violent behavior attributed to alcohol misuse accounts for 64% of murders, 41% of assaults, 34% of rapes, 29% of other sex crimes, 30% of suicide, 56% of fights or assaults in the home and 60% of child abuse. When alcoholism is treated, associated violent behavior is known to decrease.

Effective business and industry employee alcoholism programs show recovery rates of 65-80%. Air Force and Navy rehabilitation programs report 70-80% recovery rates. Community treatment facilities report recovery rates of 50-70%. Education, early detection and community-based treatment are the greatest forces operating today for the prevention, control and reduction of alcoholism.

(The above statistics were printed by the National Council on Alcoholism, Inc., 2 Park Avenue, New York, New York 10016, April 27, 1976.)

Alcoholism is America's most neglected treatable disease, with an estimated number of cases totaling 10 million in 1976. It is outranked only by cardiovascular disease in number of victims and affects approximately the same number of persons as the many forms of mental illness combined. (National Information Bureau, 419 Park Ave. South, New York, New York 10016, 1976.)

A study conducted by the National Institute on Drug Abuse pegged the costs of drug abuse to society in terms of crime, medical treatment, custodial care and loss of work at $10.3 billion. The same study showed that the costs of alcohol abuse to society have now risen to $32 billion annually. Although the cost impact for alcohol problems is three times more than for other drug problems, the federal government spends only one-third as much for alcohol abuse prevention and treatment as it does for drug abuse programs—$140 million compared to $435 million for drug abuse. (The Bottom Line, Vol. 1, No. 1, Spring, 1977.)

Almost one out of every five American adults (18%) now say that alcohol has been a cause of trouble in their families. In 1974, the comparable figure was 12%, according to the 1977 Gallup Poll. The survey also found a growing number of adults who felt drinking was a serious problem among youth, indicating that 55% of American adults classed drinking in the "serious problem" category for youth in their local communities. The percentage of adult drinkers in the U.S. has reached a 38-year high point. Between 1965 and 1975 the per capita consumption of absolute alcohol in the U.S. increased by 33%, with every known indicator of alcohol problems reflecting this trend. (The Bottom Line, Vol. 1, No. 2, Summer, 1977.)

Currently, one person in four (24%) states that an alcohol-related problem has adversely affected his or her family life. The proportion saying liquor has been a cause of trouble is as high as one-third among persons who are separated or divorced. The latest nationwide drinking audit shows 71% of adults saying they use alcoholic beverages such as liquor, wine or beer, while only 29% are abstainers. (The Gallup Poll, 1977, printed in The Omaha World Herald, July 2, 1978).

In a poll based on personal interviews with 1,523 adults conducted in more than 300 scientifically selected areas across the nation, it was found that one-half of all parents said they set no guidelines regarding the use of alcohol by their children. A significant number of those polled showed a lack of awareness about alcohol risks, the need to set guidelines for themselves and their children, and what to do if their families are hit by alcohol-related problems. (The Gallup Poll, 1977, printed in The Omaha World Herald, July 3, 1978.)

About one-third of high school students in the U.S. get drunk at least once a month; an estimated 1.3 million boys and girls between the ages of 12 and 17 have serious drinking problems, and 60% of those killed in drunken-driving accidents are teenagers. The number of teenagers arrested for drunken driving has tripled since 1960. (Figures from the National Institute on Alcohol Abuse and Alcoholism, reprinted in Alcohol: The New Teen-Age Turn-On, The Associated Press, 50 Rockefeller Plaza, N.Y., N.Y., 1975.)

LOCAL STATISTICS

In Omaha, 41.5% of junior high school respondents and 78.2% of high school students report beer drinking more than once or twice a month. The first significant increase in use of alcohol, and smoking tobacco and marijuana occurs between 7th and 8th grade.

In the Omaha area there are an estimated 28,000 alcoholics. The average family size is 2.1. That means that at least 48,800 people, many of them children and teenagers, are living in alcoholic homes.

37.8% of students with an A grade average report using beer, the beverage of choice among youth; 56.4% of students with a B grade average report using beer—the percentages increase to 78.7% of students drinking beer who earn below a C average in school. In Omaha only 15.8% of elementary school students have received any alcohol education in school; 31% of junior high and 14.4% of senior high school students have received alcohol education. (These local figures are taken from Akers, 1977.)

Alcoholism is the third leading contributing factor in child abuse and neglect in Douglas County, ranking behind unemployment and financial problems which correlate significantly with alcohol misuse. (Bengale Study, 1969)

From September, 1976 to September 1977, 864 persons from the Omaha Area received alcoholism treatment. This means that only 3% of persons needing treatment for alcoholism are receiving it. Of these 864 persons, only 23.2% were women; and Dr. Marvin Block, former Chairman of the American Medical Association's Committee on Alcoholism, states that fully 50% of alcoholic people in the United States are women. (Nebraska Division on Alcoholism, 1978.)

In a survey conducted by the Nebraska Task Force on Women, Alcohol and Drugs, mailed to approximately 2,000 women, 60% of those polled know of women with problems relating to alcohol use and 30% admit to having problems themselves. (Survey by Nebraska Task Force on Women, Alcohol & Drugs, Connie Clark & Carol Hunter, Spring, 1977.)

Between 80 and 90% of cases of spouse abuse are alcohol-related. (Nebraska Task Force on Domestic Violence, 1978)

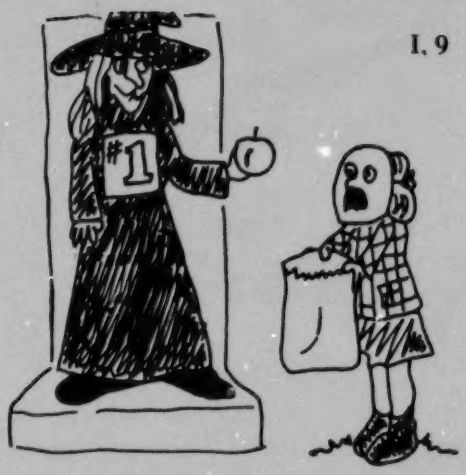
Name _____

Worksheet for "Fact Sheet on Alcohol"

1. How many people over the age of 15 consume alcohol?
2. How many people in the U. S. suffer from the disease of alcoholism?
3. What has happened to the number of known women alcoholics since WWI?
4. How many people with the disease of alcoholism are found on Skid Row?
5. How many employees are alcoholics?
6. What is the total cost to the nation a year due to absenteeism, health and welfare services, property and medical expenses?
7. Lost work time alone costs
8. Give % which are linked to the misuse of alcohol.

   Fatal accidents _____ Pedestrian accidents _____
   Fire deaths _____ Arrests _____
   Drownings _____ Admissions to state and county mental
   Home accidents _____ hospitals _____

9. The above statistics were printed by _____ in _____. (year)
10. Drug abuse costs _____ annually.
    Alcohol abuse costs _____ annually.
    Government spends on alcohol _____.
    Government spends on drug abuse_____.
11. What % of American adults say alcohol has been a cause of troubles in their families?
12. What % of persons separated or divorced say liquor has been a cause of trouble?
13. What % of parents polled in 1977 said they set no guidelines regarding the use of alcohol by their children?
14. What % of high school students in the U. S. get drunk at least once a month?
15. How many teenagers between the ages of 12-17 have serious drinking problems?
16. What % of those killed in drunken-driving accidents are teenagers?
17. What has happened to the number of teenagers arrested for drunken driving since 1960?
18. What % of Omaha junior high students drink more than once or twice a month?
19. The first significant increase in the use of alcohol, smoking tobacco, and marijuana occurs when
20. How many alcoholics are in Omaha?
21. How many Omahans live in alcoholic homes?
22. What % of Omahans use beer in Omaha?



ALCOHOL ATTITUDES

Directions:

Read the description of the fictitious people listed below and rank them on the basis of how strongly you feel about their negative characteristics. Number 1 would represent the character who you feel has the most negative (bad) characteristics, and Number 8 would have the least negative characteristics. For example, one might rank a person who deliberately gives a child an apple in which he has hidden razor blades as Number 1, and one who cheats on his diet by having a candy bar as Number 8.

Individual Rank			Group Response
_____	Friend	A person who buys beer in a grocery store to give to her friends who are under 21 years of age.	_____
_____	Counselor	A student who comes to a counselor in school to tell him/her of his involvement with alcohol and the counselor tells his parents.	_____
_____	Boozer	Person who comes to the school dance drunk.	_____
_____	Teacher	Teacher who believes very strongly that alcohol is bad and has told a few things to his/her students that weren't true just so they would be sure not to drink.	_____
_____	Father	Father who drinks a couple beers each evening to be sociable but yells when he hears his 15-year-old son has been drinking at a party.	_____
_____	Driver	A 22-year-old girl who has been drinking heavily at a party and decides to drive her friends home in her parents' car.	_____
_____	Police	Policeman who knows of a 9th grade drinking party but doesn't investigate because he says, "Kids will be kids."	_____
_____	Alcoholic	Man who argues with his wife and causes family problems because he can't hold a job.	_____

OLD MYTHS AND NEW FACTS ABOUT ALCOHOLISM

In the past, an alcoholic usually got censure instead of help: today he is viewed as the victim of a disease. The change came about through renewed efforts to understand his complex problem. And with greater understanding has come the opportunity to clear away the cloud of misconception that obscured the true nature of alcoholism-and condemned him in the first place.

Each of the following statements in heavy black type is a common misconception about alcoholism. After each statement, we supply the medical facts.

I. "Most alcoholics are on skid row"

No. Though the word "alcoholic" sometimes brings to mind a reeling, rheumy-eyed derelict, few alcoholics actually fit the description. According to recent calculations, 95 to 97 percent of our alcoholic population are not found staggering down dingy streets or huddled in dark doorways, but leading responsible lives in respectable communities. As a group, they're indistinguishable, representing both sexes, a variety of ages, and every race, creed, and calling. As individuals, most of them meet the criteria of middle-class America: they're married, have nice homes, raise a couple of kids or more, live with their families, and go to work or keep house. In numbers, they add up to an estimated nine million.

II. "Alcoholics can stop drinking if they really want to"

The alcoholic has gained an undeserved reputation for being a weak-willed person who drinks because he likes to. In the light of what is known about alcoholism, the strength of his resolve has little to do with the compulsion to drink, and he would crave alcohol even if he disliked the taste of liquor.

According to leading authorities on the subject, alcoholism is a form of drug addiction and, like other forms, involves changes in the chemistry of the body that lead to physical dependence. On withdrawal, the alcoholic becomes subject to real, not imagined, pain. Depending on how advanced his case is, he can be subjected to a nightmarish range of discomfort such as: extreme nervousness, night "sweats," leg and arm cramps, stomach pains, nausea, dizziness, uncontrollable trembling, hallucinations, convulsive seizures similar to epileptic attacks, and delirium tremens which can be fatal if untreated. Considering the relief comes with alcohol, one can readily understand why an alcoholic would be unable to simply "stop drinking" without help.

An equally difficult problem is the alcoholic's psychological dependence. He feels an overwhelming <u>need</u> to drink in order to cope with his problems, even though he knows that his drinking may have destructive consequences on his health, job arrest record, marriage, and family.

III. "Alcoholics don't want to be helped"

While authorities concede that the alcoholic seems to be singularly help-resistant, they do not interpret this as a sign that he doesn't want help. They attribute it instead to an underlying tendency to deny his condition by failing, or refusing, to recognize alcoholism in himself.

Many more alcoholics, they say, would seek help if the stigma attached to the disease were removed, and the alcoholic could openly admit to his problem without risking scorn and reproof.

Authorities also agree that at some level of understanding all alcoholics are aware of the destruction in their lives. In many cases, alcoholics become help resistant because they've been subtly (or not so subtly) rejected by people who should have helped them in the past, or because efforts to help them have not been particularly well tailored to their needs.

IV. "Women rarely become alcoholics"

Current statistics indicate that nearly two million women are alcoholics, dispelling the notion that an alcoholic woman is a rarity. And while these statistics show that intensified efforts to protect female problem drinkers against exposure lowers the probability of detection. Also, men usually feel less need, and have less opportunity, to drink unobserved, making it more difficult for them to keep alcohol addiction a secret.

V. "Alcoholics drink to escape reality"

It isn't so. Saying that an alcoholic drinks to escape reality implies that he sets out to drink himself into a state of oblivion, where his problems can't reach him. Actually, what he's looking for is a way to cope with, not to escape from, reality. If he looks for it in drinking, it's because alcohol has an anesthetic effect and dulls the sensibilities. By depressing the brain's nerve centers it not only takes the edge off physical pain, fatigue, and emotional stress, but seems to cancel out inhibiting personal characteristics-self-consciousness and timidity, for example - that might otherwise act as a barrier in dealing with everyday tensions and situations. His motive in drinking, in other words, is not basically different from that of the estimated 86 million Americans who drink and don't have any problem with it.

VI. "Heavy drinkers are alcoholics"

Not necessarily. Many authorities feel two main distinctions can be made between heavy drinking and alcoholic drinking. First. the alcoholic builds up a tolerance to alcohol, which means that his capacity for alcohol increases and it constantly takes more alcohol to have an effect on him. In the heavy drinker, the same amount of alcohol generally produces the same effect: if he drinks more than he usually does, he is affected more. Second, someone who is a heavy drinker and not alcoholic can choose where, when, how much, and with whom he drinks; he can drink or not, as he likes. In short, he has control over his drinking. With the alcoholic, it's the other way around.

Some experts, however, feel such definitions may be too narrow. Dr. Morris E. Chafetz, director of the new National Institute on Alcohol Abuse and Alcoholism, says "Alcohol abuse, in one sense, is present any time a person becomes drunk. And repeated episodes of intoxication or heavy drinking which impairs health—or the consistent use of alcohol as a coping mechanism in dealing with the problems of life to a degree of serious interference with an individual's effectiveness on the job, at home, in the community, or behind the wheel of a car—is alcohol abuse, and may raise the strong suggestion of alcoholism."

VIII. "Alcoholism strikes without warning"

Not really. Experts consider the prodromal, or early, stage of alcoholism a time of warning

before the actual onset of the disease. It is a period when a person continues to function, at least outwardly, as he always has, but displays signs of psychological dependence on alcohol, such as the following:

> . . .he tends to drink on "signal" before starting the day's work, with lunch, after dinner, at bedtime; when he's tired, when he's upset, when he's elated.
>
> . . .he always drinks more than his companions, often more than he intended, and a great deal more than he used to.
>
> . . .he can't have a good time without drinking: it's a "must" for picnics on the beach, golf, fishing, card-playing, attending football games, and the like.
>
> . . .he doesn't sip his drinks, but gulps them down.
>
> . . .he indulges in some solitary drinking, often on the sly.

There is, in addition, one important warning sign that is significant in itself. It's called "blackout."

A blackout is not the same as "passing out;" the person doesn't lose consciousness, and he may not even have had more than two or three drinks, although "blackouts" are usually produced by heavy drinking. Afterward, the drinker has no recollection of episodes following his drinking, or even that they took place.

IX. "It takes years of heavy drinking to become an alcoholic"

Not always. Once a person's drinking has gone out of control and is creating problems in the different areas of life, he is said to have become addicted to alcohol and to be in the acute stage of alcoholism. Generally, it takes an average of ten years of heavy drinking to reach that point. But there's no rule about it. For some individuals, the disease begins with the very first drink. With others, it takes three to five years of what experts consider moderate drinking. And there are people who drank heavily for 20 and 30 years before they showed signs of addiction, while others have been drinking as much and as long with no apparent ill effects.

X. "Only a certain type of person can become an alcoholic"

Researchers used to think so, too, and tried to paint a personality picture of addiction-prone individuals by studying the behavior and characteristics of chronic alcoholics. In doing so, they noted many striking similarities. The subjects were, for example, typically sensitive, easily frustrated, unable to cope with anxiety or tension, and tended toward feelings of depression and inferiority; many showed signs of emotional immaturity, hostility, guilt, and sexual problems.

But the theory simply could not stand up to scientific scrutiny, mainly because no set of characteristics could be assembled that would apply to them all. Furthermore, it could not be determined if the traits they exhibited were an inherent part of their personality, or had developed as a result of their addiction. Most authorities, in fact, are inclined to say there is no such thing as an "alcoholic personality," and any type of person is a candidate.

XI. "Alcohol is the sole cause of alcoholism"

Obviously, no one can become an alcoholic without the use of alcohol. But authorities regard

it as an agent, and not the cause of alcoholism. If it were the cause, they say, everyone who drinks would become addicted to it. Which isn't of course, the case.

What actually does cause alcoholism is still a mystery, although several unproven theories recently have been advanced. It has been suggested, for example, that there is a basic physical difference in the way alcohol is disposed of in the body of an alcoholic. Another theory is that alcoholism is caused by a glandular malfunction, and nutritional deficiency is also suspect. Some say the disease is due to an abnormal emotional background, while others attribute it to serious psychiatric illness.

The informed concensus is that psychological, physical, social, and cultural conditions all contribute to alcohol addiction. However, most authorities do not discount the possibility that a single underlying cause, sometimes referred to as the X-factor, may be at the root of the problem.

XII. "A person can't inherit alcoholism"

No evidence has been unearthed to specifically relate alcoholism to heredity, but there is a substantial amount of research that indicated alcoholism does run in families. Children of alcoholic parents, for example, are considered by authorities to be extremely high-risk individuals. And while their greater susceptibility might be accounted for by an unfavorable home atmosphere, learned attitudes regarding drinking, and imitation of adult behavior, some experts feel that the discovery of a direct genetic connection—either as a predispostion to alcoholism or an immunity to it—is not as remote as most people think.

XIII. "Alcohol doesn't cause cirrhosis of the liver"

It's long been known that only a small percentage of alcoholics—an estimated ten percent develop cirrhosis of the liver. If alcohol were the cause of cirrhosis, the reasoning once went, a much greater percentage of alcoholics would get this disease. Most medical authorities assumed that the true cause of the prevalence of cirrhosis of the liver in alcoholics (eight times more frequent) was malnutrition, caused by the inclination to drink rather than eat. But now they're not sure.

Cirrhosis of the liver means scarring of the liver, and recent studies have shown that even small doses of alcohol unquestionably cause scar tissue in the liver. Other studies confirm that when people with advanced cirrhosis of the liver stop drinking, their condition shows striking improvement. As for the theory that malnutrition is the cause of this disease in alcoholics, studies say that it's simply not so.

"For the first time," says Dr. Frank A. Seixas, medical director of the National Council on Alcoholism, "we're getting medical evidence which confirms the observations doctors have made—and dodged—for years: alcoholism and cirrhosis are very closely linked."

XIV. "Alcoholism is an allergy"

To be technical about it, an alcoholic can't be "cured." It would mean restoring him to a condition that enables him to drink in a controlled manner, and the majority of experts agree that, because alcoholism is a lifelong addiction, this usually can't be done. But the illness can be interrupted, and he can recover through abstinence and treatment.

Modern methods of treating alcoholism include: medication, which is used to ease the discomforts of withdrawal, to treat any medical complications that may be present, and sometimes to induce an aversion to alcohol; counseling or therapy, which consists of treating the psychological or emotional aspects of the problem: and Alcoholics Anonymous, a worldwide fellowship of nearly half a million people who succumbed to alcoholism and now share their own experiences in the hope of drawing strength and inspiration to solve their common problems.

Reports of success from various sources range from 15 to 80 percent, but the method employed seems to be less of a determining factor in recovery than early treatment, the patient's earnest desire to get well, and the support of those close to him.

TEENAGE ALCOHOL-RELATED PROBLEMS

NATIONALLY:

The 1977 Gallup Poll and recent youth survey by the National Institute of Alcohol Abuse and Alcoholism on drinking patterns in America shows that problems are increasing for youth.

1. 70% (17 million) of today's teenagers have had a drink.
   a) 7% more boys than girls have had some experience with alcohol.
   b) 59% of teens in the South have had at least one drink.
   c) 74-77% of teens in other parts of the country have had some experience with alcohol.

2. 21% (5 million) of teenagers reported consuming 5 or more drinks per occasion.
   30% (7 million) teens reported getting drunk several times each year or having other negative consequences as a result of drinking.

3. The average age at which young people have their first drink is 12.9 years.

4. The average number of drinking occasions has increased from 2.5 per month in the 1960's to 3.1 per month in the 1970's.

5. More than 62% of all 7th graders and 80% of all 12th graders now drink.

6. Between 27% and 43% of teenagers who are arrested for committing a crime had been drinking at the time.
   Other problems associated with alcohol abuse among youth include:
   A. Impaired driving performance
      a) 60% of traffic fatalities among youth involve alcohol. Nearly 8,000 young Americans are killed each year in accidents involving young people and alcohol. 40,000 more are disfigured.
      b) 1960-13,537 arrests of youth under 18 for driving while intoxicated.
      1971-31,173 arrests of youth under 18 for driving while intoxicated.
   B. Disturbed interpersonal relationships.
   C. Impaired School Performance.
   D. Impaired Job Performance.

7. Frequency of Teenage Drunkenness
   45% have been drunk at least once.
   12% have been drunk once a month.
   5% getting drunk once a week.

8. The January 1977 issue of Prevention and Education printed by the National Council on Alcoholism reported results from a survey conducted in San Fransisco among 3500 fourth, fifth, and sixth graders:
   45% considered themselves users of alcohol
   20% reported drinking alcohol once a month
   8% reported being drunk once a month
   9% reported problems relating to alcohol intake

FACT SHEET-WOMEN & ALCOHOL

Drinking Practices of American Women

*The proportion of adult women who drink has been increasing steadily since World War II, and the results of recent surveys indicate that this is continuing. About 47 percent of adult women now drink once a month or more.

*However, men are nearly twice as likely to be moderate drinkers and three times as likely to be heavy drinkers in comparison with women.

*The highest proportion of heavier drinkers occurred among men aged 18 to 20 and 35 to 39. Women aged 21 to 29 had the highest proportion of heavier drinkers.

*There is a reported increase in the number of women exhibiting alcohol problems. Ten years ago, one out of every six persons with an alcohol problem was a women, now it is one out of three. In a 1974 survey, Alcoholics Anonymous found that one out of every three new members in the last three years was a woman, and that women account for 28 percent of AA's total membership.

*Preliminary findings from the 1974 national survey of junior and senior high school students indicate that among seventh graders, 63 percent of boys and 54 percent of girls have had a drink . . . the proportion of teenage drinkers increased with grade to 93 percent of twelfth-grade boys and 87 percent of twelfth-grade girls.

*The use of alcohol among girls has approached that of boys, though the proportion of girls who drink at least every week is smaller. There has been an increase in the drinking frequency of all students at each grade level.

Why Women Drink

*In a 1957 comparison study of male and female alcohol outpatients by Edith Lisansky, she discovered that male patients began drinking at an earlier age than women and came to the clinic with a longer history of problem drinking. All the women studied attributed the onset of heavy drinking to a specific life crisis, such as a parent's death, divorce, or post partum depression. Only half the men studied reported a life crisis as a precipitating factor.

*Another researcher, Joan Curles (1970) observed the same characteristic in her subjects. She states that female drinking is often precipitated by a "middle age identity crisis," such as the death of a husband, divorce or menopause.

*Barry Kinsey, in 1966, found that marital disruption and instability seem to be precipitating factors in female alcoholism. Kinsey's study shows a high rate of broken marriage and divorce, and marital relationships were characterized by jealousy, brutality and chronic conflict.

*With the development of occupational alcoholism programs, the working woman may have a better chance of seeking help for her alcoholism than the house-wife. On the job, her problem is more visible to those around her. If she is lucky enough to work for a company with an employee alcoholism program, she has a greater chance of detecting her problem in the earlier phases of her illness.

*Vera Lindback (1972) tells us that studies indicate that the alcoholic wife receives less understanding and acceptance than the alcoholic husband. She adds, "Among therapists as well as the lay public, the nonalcoholic spouse of the drinking male is suspected of contributing to her husband's drinking, but the nonalcoholic spouse of the alcoholic woman is more likely to be regarded as a deprived person, one who receives more sympathy than censure.

*The alcoholic woman has a higher divorce rate than the alcoholic man. Lindback believes that the above-mentioned lack of understanding and societal censure contributed to this divorce rate.

*Shuckit (1972) "The scorn which is felt foi the drunk male is felt with even greater intensity for the drunk woman. Social custom once denied women access to public drinking places, with a few special exceptions. Bar maids and "female companions" were there for the male patrons' pleasure. Any woman seen alone in a bar was assumed to be a prostitute . . . By extension, any woman who was drunk, or even drinking, might have been perceived in the same context."

*Chafetz (1974) "Once women establish a heavy drinking pattern, they generally develop alcoholism much more rapidly than men. Evidently, it appears that greater condemnation, fear of being a social outcast, and feelings of guilt contribute both to the concealment of drinking and its telescoped development in women."

REFERENCES

Alcohol and Health - New Knowledge, DHEW Second Special Report to Congress, July 1974).

Chafetz, M., Press Conference, New York, N. Y., October 1974.

Colen, B. D., The Infant Alcoholics, Washington Post, February 2, 1975.

Fraser, J., The Female Alcoholic, Addictions, 20(3):64-80, 1973.

Jones, K. L.; Smith, D. W.; Ulleland, D. N.; and Streissguth, A. P., Pattern of Malformation in Offspring of Chronic Alcoholic Mothers, Lancet I, 11267-71, June 9, 1973.

Kinsey, B. A., The Female Alcoholic: A Social Psychological Study, Springfield, Ill.: Charles C. Thomas, 1966.

Lindbeck, F. L., The Woman Alcoholic: A Review of the Literature, Int J. Addictions, 7(3):567-580, 1972.

Paredes, A., Marital Sexual Factors in Alcoholism, Medical Aspects of Human Sexuality, April 1973.

Sanchez-Dirks, R., Women and Alcoholism, Food & Drug Administration Speech, January 1975.

Schuckit, M. The Alcoholic Woman: A Literature Review, Psychiatry Med. 3:37-40, 1972.

Wilsnak, S. C., Femininity by the Bottle, Psychology Today, 6(1):39-43, 1973.

National Clearinghouse for Alcohol Information, February 1975.

High Risk Groups

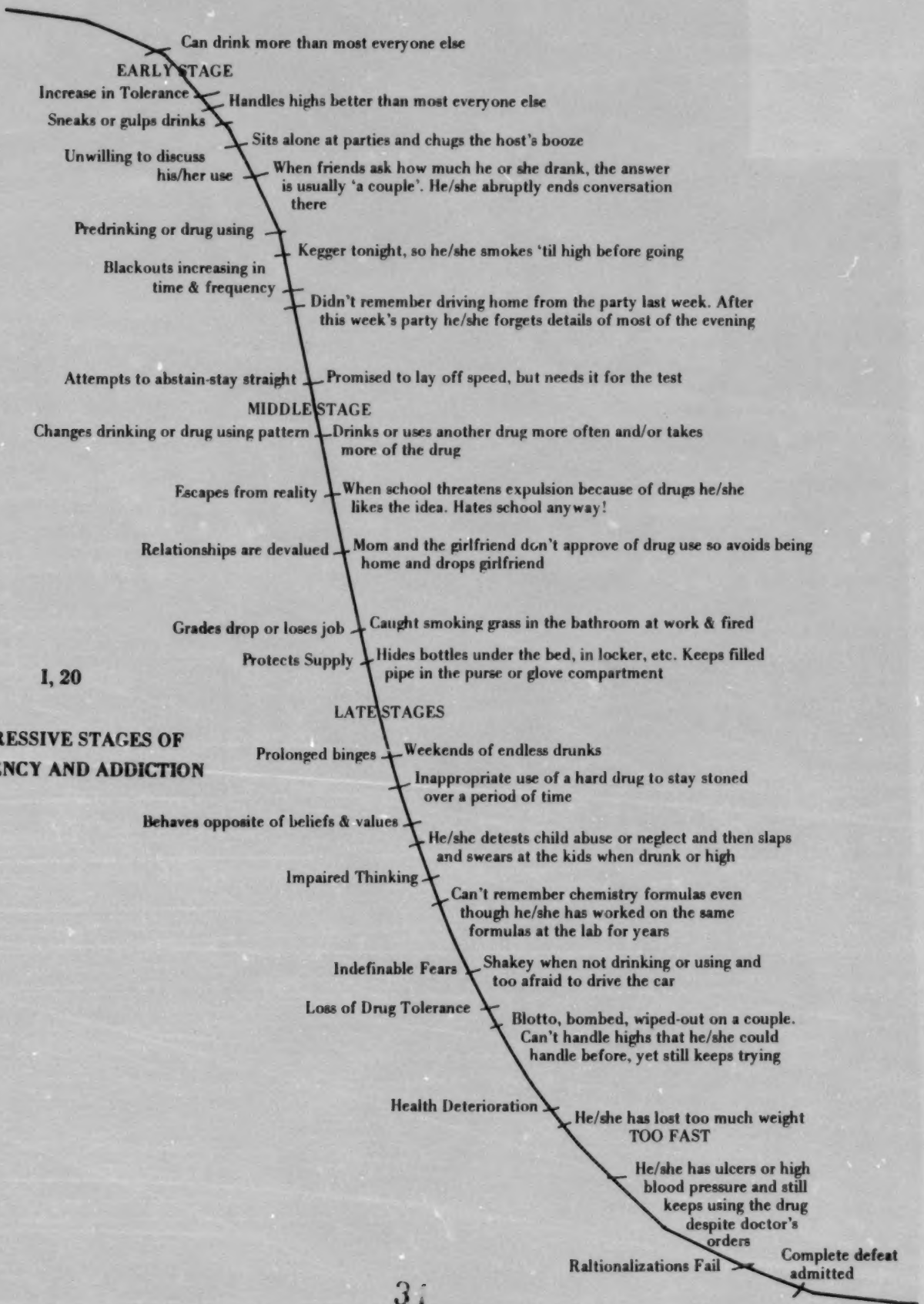
OBJECTIVE

Although present research is not in agreement regarding the cause of alcoholism/chemical dependency, "Statistical" research proves that certain people are at RISK. The student will become knowledgeable of High RISK group studies and will be encouraged to make his/her own decisions about his/her own risk with drugs.

ACTIVITY

1. The teacher will present statistical information to the class regarding High Risk Groups.
   a. Children of Alcoholics/CD's – 50-80% increased risk.
   b. Children of non-drinking parents – higher than normal risk.
   c. American Indians who drink – 80% of all who drink will drink in an alcoholic manner.
   d. Hispanic descent population – High Risk vs general population.
   e. Eskimo population – 80% of those who drink will drink in an alcoholic manner.
   f. Jewish descent – low risk vs Irish-higher risk.
   g. The French population have twice the alcoholism rate as the Italians - statistically.

2. Discussion questions: If children of alcoholism have higher risk and children of teetotalers are at greater risk for alcoholism, why do you think this is possible? Challenge - Can you find an answer as you continue your studies?
   a. Conduct an open-ended discussion.
   b. Break up the class in small groups with a peer facilitator.
   c. Have a student(s) prepare a research report on the subject of High Risk and present this information to the class.

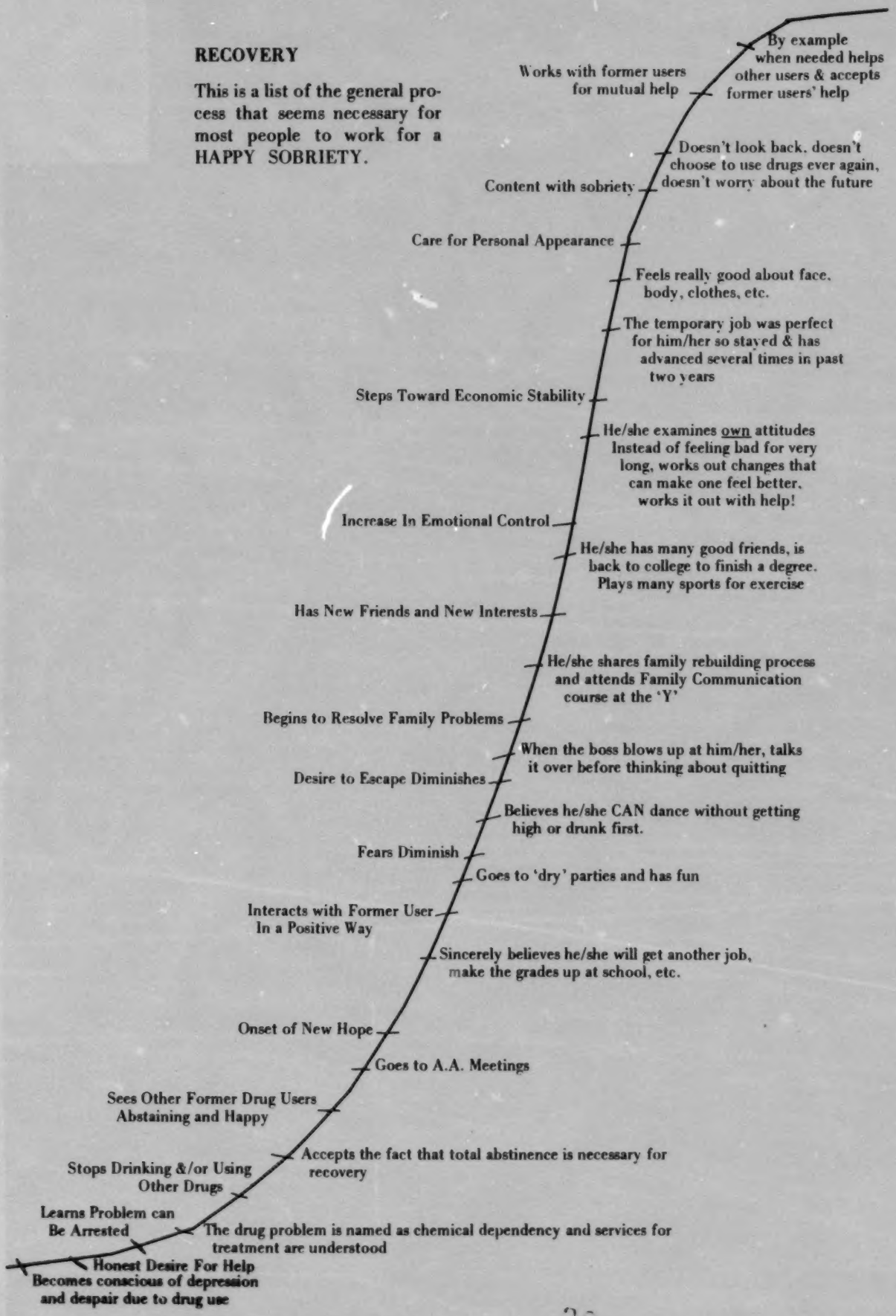

Can drink more than most everyone else
EARLY STAGE
Increase in Tolerance
Handles highs better than most everyone else
Sneaks or gulps drinks
Sits alone at parties and chugs the host's booze
Unwilling to discuss his/her use
When friends ask how much he or she drank, the answer is usually 'a couple'. He/she abruptly ends conversation there
Predrinking or drug using
Kegger tonight, so he/she smokes 'til high before going
Blackouts increasing in time & frequency
Didn't remember driving home from the party last week. After this week's party he/she forgets details of most of the evening
Attempts to abstain-stay straight
Promised to lay off speed, but needs it for the test
MIDDLE STAGE
Changes drinking or drug using pattern
Drinks or uses another drug more often and/or takes more of the drug
Escapes from reality
When school threatens expulsion because of drugs he/she likes the idea. Hates school anyway!
Relationships are devalued
Mom and the girlfriend don't approve of drug use so avoids being home and drops girlfriend
Grades drop or loses job
Caught smoking grass in the bathroom at work & fired
Protects Supply
Hides bottles under the bed, in locker, etc. Keeps filled pipe in the purse or glove compartment
LATE STAGES
Prolonged binges
Weekends of endless drunks
Inappropriate use of a hard drug to stay stoned over a period of time
Behaves opposite of beliefs & values
He/she detests child abuse or neglect and then slaps and swears at the kids when drunk or high
Impaired Thinking
Can't remember chemistry formulas even though he/she has worked on the same formulas at the lab for years
Indefinable Fears
Shakey when not drinking or using and too afraid to drive the car
Loss of Drug Tolerance
Blotto, bombed, wiped-out on a couple. Can't handle highs that he/she could handle before, yet still keeps trying
Health Deterioration
He/she has lost too much weight TOO FAST
He/she has ulcers or high blood pressure and still keeps using the drug despite doctor's orders
Raltionalizations Fail
Complete defeat admitted

I, 20

PROGRESSIVE STAGES OF DEPENDENCY AND ADDICTION

RECOVERY

This is a list of the general process that seems necessary for most people to work for a HAPPY SOBRIETY.


By example when needed helps other users & accepts former users' help
Works with former users for mutual help
Doesn't look back, doesn't choose to use drugs ever again, doesn't worry about the future
Content with sobriety
Care for Personal Appearance
Feels really good about face, body, clothes, etc.
The temporary job was perfect for him/her so stayed & has advanced several times in past two years
Steps Toward Economic Stability
He/she examines own attitudes Instead of feeling bad for very long, works out changes that can make one feel better, works it out with help!
Increase In Emotional Control
He/she has many good friends, is back to college to finish a degree. Plays many sports for exercise
Has New Friends and New Interests
He/she shares family rebuilding process and attends Family Communication course at the 'Y'
Begins to Resolve Family Problems
When the boss blows up at him/her, talks it over before thinking about quitting
Desire to Escape Diminishes
Believes he/she CAN dance without getting high or drunk first.
Fears Diminish
Goes to 'dry' parties and has fun
Interacts with Former User In a Positive Way
Sincerely believes he/she will get another job, make the grades up at school, etc.
Onset of New Hope
Goes to A.A. Meetings
Sees Other Former Drug Users Abstaining and Happy
Accepts the fact that total abstinence is necessary for recovery
Stops Drinking &/or Using Other Drugs
Learns Problem can Be Arrested
The drug problem is named as chemical dependency and services for treatment are understood
Honest Desire For Help
Becomes conscious of depression and despair due to drug use

CHEMICAL DEPENDENCY STAGES-SUMMARY

NOTE: All symptoms listed are dependable signs of the disease, but caution: not all the symptoms may appear in any individual case and they may not occur in the order listed.

The behaviors listed are symptomatic of chemical dependency - pathological drinking and drug using - as opposed to "normal," "social," or "heavy drinking."

EARLY STAGE

Significant symptoms: Memory lapse after relatively moderate social drug usage. The drug usage may still not be regarded as too unusual by friends or family. Abstinence and treatment at this stage are necessary to prevent advanced consequences of the disease. Treatment at this time will be far easier and most productive.

MIDDLE STAGE

Significant symptoms: All middle and late stage symptoms are significant. This stage is often referred to as the crucial phase of addiction. The stage is marked by consequences. Problems will be noted in several areas; work, home, finances, friends are lost and inter-personal relationships are suffering or severely damaged. Suicide attempts or actual deaths become a possibility. Treatment becomes imperative.

LATE STAGE

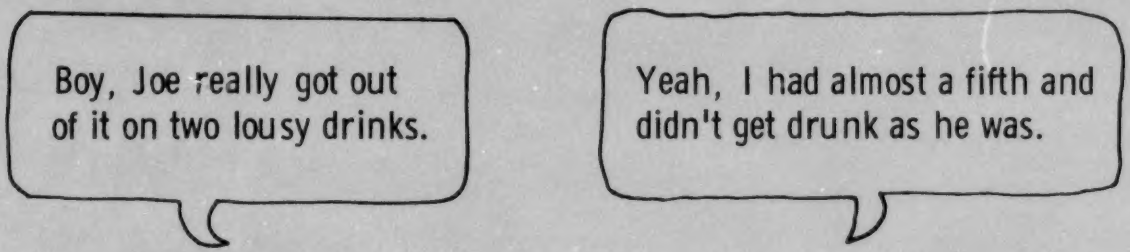
Distinguishing Symptoms: Obsessive, often continuous use of the drug. There may be irreversible brain, liver, nerve, etc., damage. There is an inability to manage responsibilities of life, such as the job, school, family, etc. Early death may occur due to physical deterioration or by accident. Motivation for treatment is often far more difficult, but recovery with treatment and abstinence offers the only promise for reconstruction of one's life.

OACA Omaha Area Council on Alcoholism

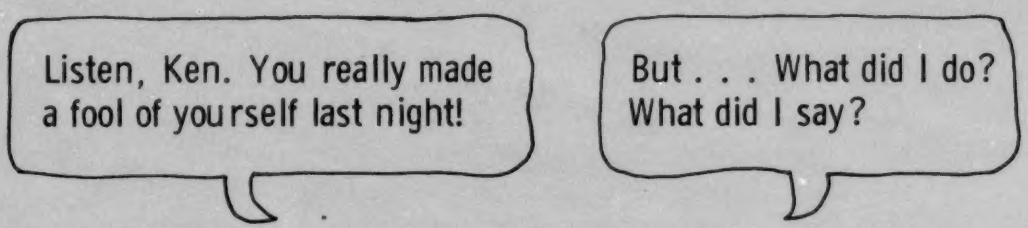
113 North 18th Street · Omaha, Nebraska 68102 · Phone: 345-4080

EARLY WARNING SIGNS OF ALCOHOLISM

Do you think or say these things?
You may have a drinking problem.



- Unusually high tolerance to alcohol . . .



- Lapse of memory when drinking . . .

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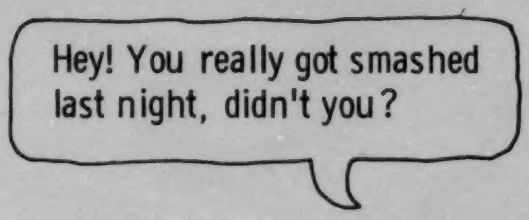
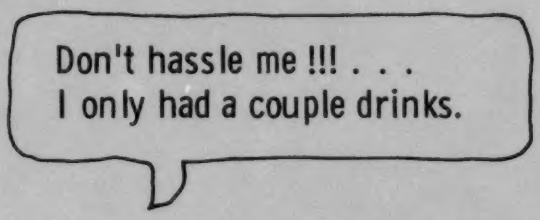
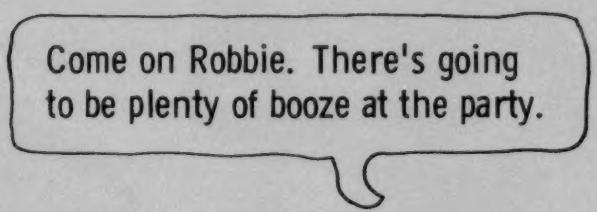
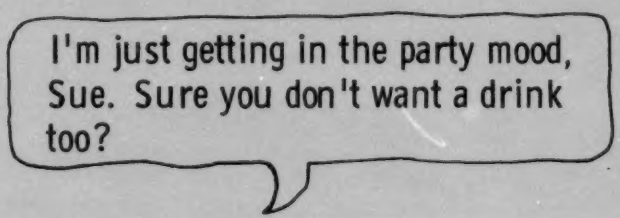




- Lying about or minimizing amount of drinking . . .





- Pre-drinking drinking . . .

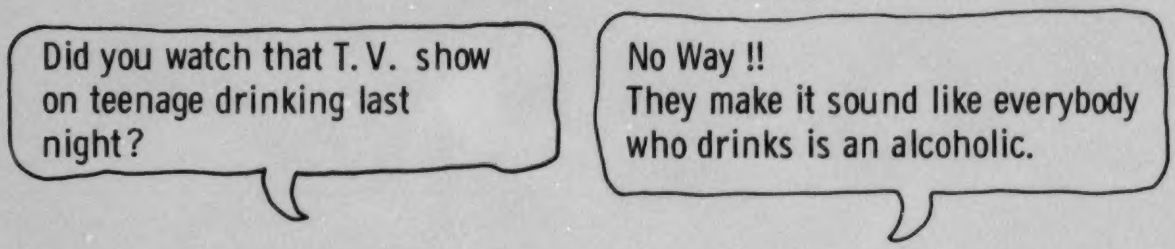
I haven't seen you sober in the last 3 months.

I can't help it if I only see you when I'm partying.

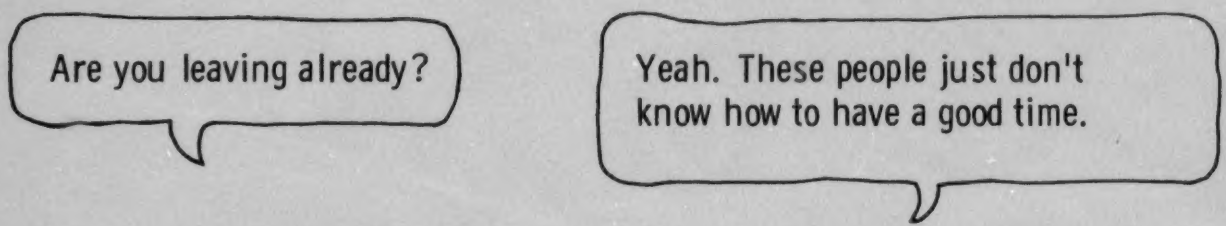
•Frequent drunkenness . .

Okay, I'll pick you up at seven to go to the party.

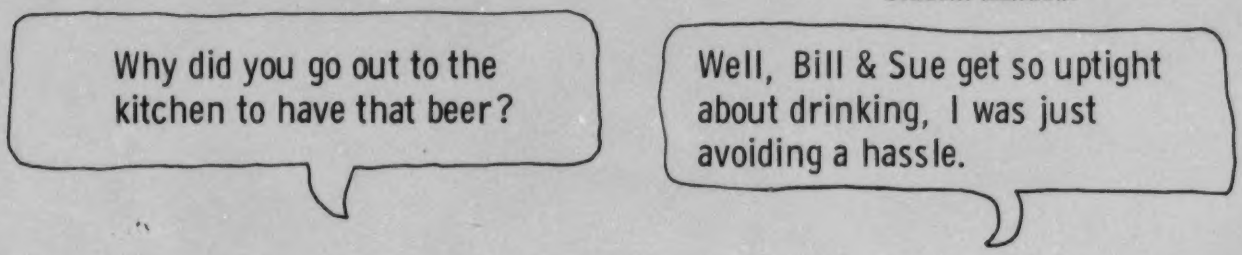
•Preoccupation with drinking . . .


Did you watch that T. V. show on teenage drinking last night?
No Way !!
They make it sound like everybody who drinks is an alcoholic.

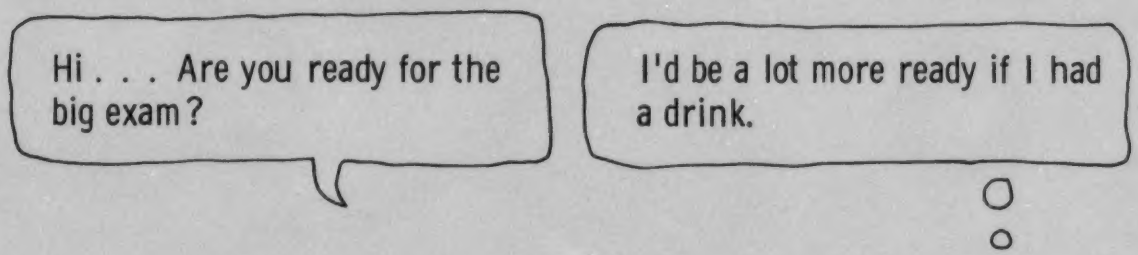
•Uncomfortable when drinking is discussed . . .



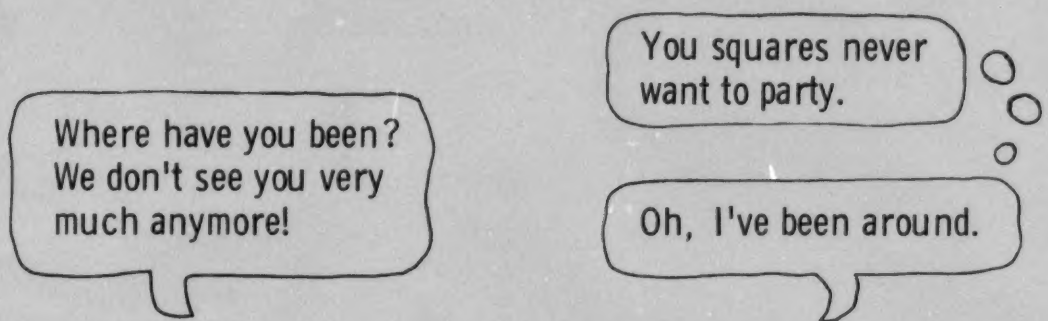
•Uncomfortable when liquor is not served . . .



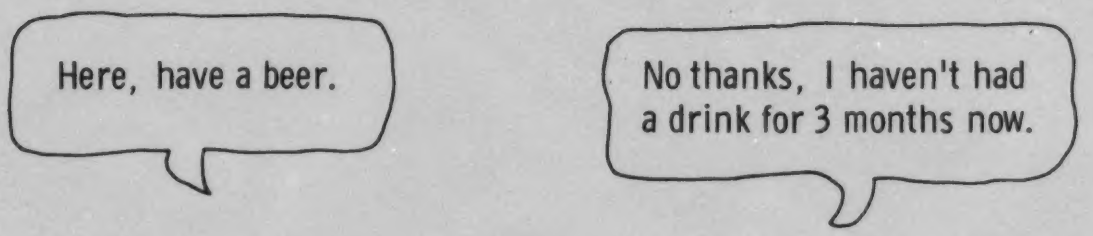
•Sneaking drinks . . .



•Pattern of needing a drink in stress situations . . .



•Changing to friends who drink more . . .



•Going on the wagon . . .

ALCOHOLISM IS A DISEASE WHICH CAN BEFALL ANYONE WHO DRINKS ALCOHOL, REGARDLESS OF AGE, SEX, ECONOMIC OR SOCIAL STATUS. ALCOHOLISM IS A TREATABLE DISEASE, AND EARLY DETECTION AND TREATMENT MAY SAVE YOUR LIFE, OR THE LIFE OF SOMEONE YOU KNOW.

FOR HELP, OR FOR MORE INFORMATION, CALL 345-4080

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STUDENT DISCUSSION QUESTIONS

FROM YOUR OWN PERSPECTIVE:

(a) Given as a percentage, how many students in your school do you feel drink? _____ %

(b) On an average, how often do they drink? _____
(weekly, monthly, rarely, other-specifically)

(c) How much do they drink on the average? _____

(d) How often do you drink? _____

(e) How much do you drink each time? _____

SITUATIONS FOR "PROBLEM vs NON-PROBLEM DRUG USAGE" ACTIVITY

Directions: The teacher will read each situation. The class will respond "problem or non-problem", explaining why the answer was chosen. Discussion by class to reach consensus is encouraged.

Objective: To identify problem chemical usage.

Family Problems

1. The kids are embarrassed by their parents' behavior at cocktail parties.
2. The parents are worried when they find a bag of grass in Johnny's drawer two weeks after Johnny swore he'd never use the stuff again.

Legal Problems

1. The iron worker is brought to court for a 3rd offense of assault during a bar room brawl. The charges are dropped.
2. A teen is sent to court for his 2nd M.I.P. charge of the summer.

Work and School Problems

1. Mr. Jones drinks for lunch and returns to work late, drunk again.
2. Betty goes out to smoke pot at noon and comes back late for class, higher than a kite.

Social or Interpersonal Problems

1. The bride, on her wedding day, drinks too much during the reception and throws up at the reception.
2. At parties, Joe's girlfriend gets mad at Joe as he sits alone and gets loaded. He ignores everyone and everything going on at the party without him.

Self

1. Allen flirts and uses profanity when drinking at the bar and later is ashamed to face the girl he was with.
2. Mrs. Miller feels guilty when the kids come home with friends to find she and Mr. Miller smoking grass.

Health

1. Mr. Jones continues to drink even after the doctor warns him that his ulcer is getting worse due to smoking and drinking.
2. Mary's husband is concerned as Mary continues to take more pills than prescribed and she's using them more frequently.

DEFINITION AND INTRODUCTION TO CAUSES

Although alcoholism has presented social, legal, physical and medical problems since at least Biblical times, it has only been with the coming of the 20th century that professionals have delved into the causes of alcoholism and that effective treatment has been discovered. This does not mean, however, that all of the answers have been found. Professionals in the still-infant fields of alcoholism and chemical dependency debate among themselves about the causes of, the definition for, the problem. Some believe chemical dependency to be a moral weakness. Others think that it is primarily a physiological problem. Some say it is simply a symptom of deeper underlying psychological problems. Others suggest that the answer lies in a combination of all of these factors.

As laymen, it seems almost pointless to debate these questions that fulltime doctors, scientists, psychologists, psychiatrists, and social workers cannot solve. We can, however, be sure of two things: alcoholism and chemical dependency can be IDENTIFIED and they can be TREATED.

The objective of this section is to teach students ways to identify c.d. and to suggest that c.d. is not a hopeless situation: it can be arrested and treated.

Classroom Teaching Technique

Senior High – Students often have difficulty grasping the concept of "problem" drug usage and they may feel that a C.D. or Alcoholic is an "older" person than themselves. Use examples, situations, etc. that dispel this myth!

There are many approaches to, definitions of, and attitudes toward alcoholism. As with any newly organized and recognized field of study, the answers are not all in. Professionals in the field of alcoholism and chemical dependency debate among themselves as to the causes of, and treatment for the problem. Consequently, at the present, it falls on the non-professional to make decisions and judgments that later research and data may prove wrong. Therefore, it is important to retain an open mind and a willingness to explore new ideas. It may well be that curriculum developed now may be outdated and useless in a matter of years.

What is Alcoholism

There are three traditional viewpoints of alcoholism:

The first, and no doubt the oldest, is that alcoholism is a form of moral weakness, that the alcoholic drinks because he or she lacks will power. This attitude encouraged the view that alcoholics are "bad", "weak", or "immoral" people who need only to "grow up", "straighten out", or "use their will power" to drink safely and normally, or perhaps to not drink at all. The alcoholic is viewed an "irresponsible" or as someone who "should know right from wrong".

This viewpoint leads to remarks such as,

"If only he'd use his will power . . ." or

"He just needs to grow up . . ." or

"She's just irresponsible and you might as well forget her . . ."

We do not apply standards such as these to other health problems such as cancer, tuberculosis or epilepsy. We do not hear remarks like,

"If he'd only use his will power, he wouldn't have cancer (or "wouldn't cough so much," or "wouldn't have convulsions").

The second viewpoint which has gained popularity in the 20th century along with the development of psychiatry and the field of mental health, is that alcoholism is a symptom of underlying psychological problems. This school believes that alcoholics drink because of pre-existing emotional or psychological causes. With this viewpoint, it is easy to jump to the conclusion that once the underlying problems are recognized and dealt with, the alcoholic can, and will, resume normal drinking.

This attitude leads to remarks like,

"If you had all those problems, you'd drink too"

"My mom drinks because she was an orphan" (or "because my dad left her" or "because she has so many kids.")

"My dad drinks because he lost his job" (or "because he has a bad back" or "because my mom yells at him all the time.")

The third viewpoint is that alcoholism (or chemical dependency) is a physically based disease that causes secondary problems in all areas of life. This approach suggests that there is a physical reason that alcoholics drink obsessively or uncontrollably.

There is ample evidence to suggest that the disease concept is a valid one. Alcoholism can be considered a disease because, like other diseases,

- IT HAS SYMPTOMS
- THE SYMPTOMS ARE PROGRESSIVE
- IT CAN BE DIAGNOSED
- IT IS TREATABLE

Other evidence supporting the disease concept:

1. In 1956 the American Medical Association agreed to define alcoholism as a disease.
2. Health insurance companies pay for hospitalization and treatment of alcoholism and chemical dependency.
3. Like other diseases, alcoholism strikes regardless of age, race, education, social standing, etc.
4. Recent research indicates an alcoholic's body reacts differently to alcohol than a non-alcoholic's body.

CHEMICAL DEPENDENCY AS A DISEASE

Chemical dependency is essentially a pathological or sick relationship of a person to a mood - altering chemical substance, a psychoactive drug, in expectations of a rewarding experience. (Robert M. and Mary B. McAuliffee, PHD's)This definition refers to a pathological, sick, ill, diseased, etc. deviation from normal health caused directly by that person's relationship to a drug to chemically and powerfully change the way he/she "feels". The process of development progressing into destructive events or resulting conditions are the elements of pathological dependency.

STAGES OF CHEMICAL DEPENDENCY

There have been references throughout this lesson to "degrees" of illness, "variance" in symptoms and "progression" of the disease. As all individuals are unique, each case of chemical dependency is different, yet there will be some symptoms that significantly repeat and cause problems. Symptoms become more intense and more recognizable as the disease progresses. All symptoms need not be present. All stages may not follow the stage progression. Rate of time in the progressive pathology may differ. However, if there are significant symptoms, repeating and progressing, then the identification of a drug problem is possible and necessary.

Chemical dependency is a highly treatable disease, and easier to treat the earlier it is detected! The stages given represent Early, Middle and Late stage dependency. The symptoms are represented in the stages and illustrated by examples to assist the teacher in conveying the information to the student in recognizable situations.

ALCOHOLISM AS A DISEASE

Dr. James E. Milan, PH.D., author of "The Emergent Comprehensive Concept of Alcoholism", has attempted to define alcoholism.

"Alcoholism is a primary, progressively pathological constitutional reaction to the ingestion of alcohol, psychosocial symptoms are secondary, derivitive and progressive irregardless of premorbid psycho-social antecedants."

Again, his definition describes the pathological or diseased state and distinguishes the psychosocial symptoms as "caused by" the disease state not causative of the disease. The disease is a primary disease due to the effect upon the person by the drug. The effect is temporary or prolonged loss of control and the pattern is progressive at varying rates.

Any disease must have 1) an etiology or causation (even if unknown), 2) a specific set of symptoms and methodology for diagnosis, 3) an appropriate and workable treatment, and 4) a prognosis. Diagnosis is primarily determined by the number of symptoms and the severity of the symptoms. Unless alcoholism is interrupted and treated successfully, the prognosis is death and insanity. The life expectancy of an alcoholic is usually ten or more years less than the

ALCOHOLISM AS A DISEASE (Continued)

national average. Even with treatment, the disease is "arrested" not cured and becomes an active recovery process contingent on the alcoholic's own efforts with support such as A.A.

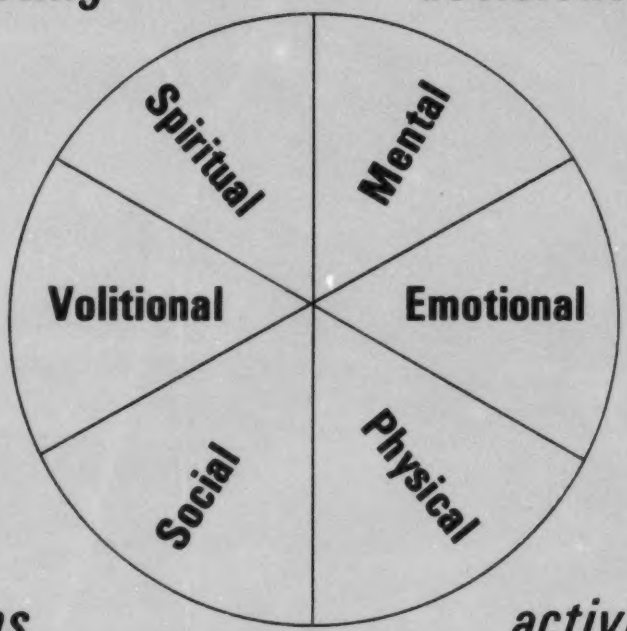
With the potentially chemically dependent person the first drink may be a virtual answer to a prayer "instant ease, camaraderie, courage, answer to stress, etc". The effect of the overwhelmingly good feeling is pursued for rewards of the drug's experience. The dependency grows as the compulsive and obsessive use grows. Physical addiction becomes apparent when the drug usage brings about withdrawal symptoms such as stomach cramps, nausea, tremors, sweating, even hallucinations and convulsions. Withdrawal may be subtle or acute but the answer for the alcoholic or the chemically dependent person rests within the rewards of the drug. The chemically dependent person loses sight of the cause of the problem, the drug becomes the answer to the problem.

"Any drug will work for the chemically dependent/alcoholic individual, "any" drug that sedates, stimulates or changes the mood. Exchanging dependencies is a real danger.

CHEMICAL DEPENDENCY AFFECTS

values affecting behavior

decisions, judgement



goals, willpower

feelings

relationships

activities, senses

ALL!

AREAS OF LIFE

WHAT KIND OF PROBLEM IS ALCOHOLISM?
IT ALL DEPENDS WHO'S LOOKING . . . WHAT SHAPE IT IS

A simple illustration of the complexity of the problem:

A man and wife have a serious disagreement of long standing over his drinking.

A MARITAL PROBLEM – They need marriage counseling.

As a result of a fight he leaves, gets drunk and is picked up driving under the influence:

A POLICE PROBLEM AND PUBLIC SAFETY

He is taken to jail and thrown in the drunk tank. Since he has been drinking large amounts regularly, he goes into withdrawal in jail and has convulsions.

A MEDICAL PROBLEM – He needs a doctor and treatment.

He is taken before the judge who is seeing him for the eleventh time on an Alcohol-related charge:

A LEGAL PROBLEM – (New legal concept on Alcoholism)

The judge sentences him to 90 day in the County Jail, which causes the man to lose his job. His wife and five children have no money and no means of support, hence:

A WELFARE PROBLEM

The 16-year-old son is picked up by the police for stealing:

A JUVENILE COURT PROBLEM

The 14-year-old daughter is failing in school and has a long record of unexcused absences.

A SCHOOL PROBLEM

Having served his sentence in jail, the man is released to begin all over again the vicious cycle of destruction of self and family.

<u>WHAT KIND OF A PROBLEM IS IT?</u> <u>WHOSE RESPONSIBILITY IS IT?</u>

This man is still insisting he is not Alcoholic and has no desire or need to stop drinking.

<u>WHAT DO WE DO NOW?</u>

THE BARE FACTS OF LIFE - ABOUT ALCOHOLISM

The following statements are basic assumptions necessary to an understanding of, and appreciation for, the problems created by Alcoholism.

1. Cause – There are numerous theories, speculations and notions, some of which are strongly supported, but as yet no scientific proof exists which identifies a specific single or multiple causation for Alcoholism. Apparent are physical, emotional, spiritual and cultural factors.

   To the best of our knowledge today, drinking has the same relationship to Alcoholism that gasoline has to automobile accidents. It's not the cause.

2. Alcoholism is an illness – It is other things too – social problem, legal problem, economic problem and family problem. This multiplicity of ways in which it can be viewed has added to the confusion and encouraged the perpetuation of unrealistic stereotypes.

3. Not all alcohol problems are alcoholism – The age-old arguments about the rights of wrongs of drinking have nothing to do with Alcoholism. They, too, confuse the real issues.

4. There is considerable debate between knowledgeable people about whether alcoholism is "the problem" or whether it is but a "symptom" of some underlying psychological problem or personality disorder.

   EITHER WAY . . .
   Alcoholism as a distinct problem is treatable.
   EITHER WAY . . .
   Alcoholism as a symptom is treatable.

5. Alcoholism is easily diagnosed – It is best distinguished by "loss of control." A person cannot consistently drink as he intends to drink.

6. The course, the progression of Alcoholism is Exquisitely Predictable (see Jellinek)

7. At our present level of knowledge . . .

   A. Early recognition B. Intervention C. Abstinence

   . . . Reinforced by A.A. or some other group-help, therapy is the most effective way of combating alcoholism. Nothing else is even a close second.

8. Our society – especially family groups, employers and friends, by their attitudes and behavior, contribute generously to the maintenance of the drinking and the developing alcoholism. Then they put barriers in the way of recovery.

9. Recovery from Alcoholism is born in Pain and Misery. No other motivation has been found that will successfully turn a man from his course of inevitable self-destruction. Nobody yet ever began recovery as a pure volunteer; he was driven.

10. Successful intervention -or- motivating the problem drinker to seek help for his problem is best and most quickly accomplished by a change in the attitudes and behavior of the family or employer, which increase the pain or make the continued drinking too costly to endure.

    Letting him bear the full brunt of the responsibility of his own behavior.

    Giving him a clear cut choice with no room for compromise.

11. Sobriety is not a total answer! The elimination of a drinking problem does not automatically solve all other problems. In fact, by itself it solves nothing. It does, however, make it possible to identify the "other" problems. These problems may require a simple readjustment, which can be adequately handled by the ex-drinker or they may involve extensive help by a number of agencies and/or professions.

12. Acting out of Hostility – or to Punish Him – is Futile – Precisely like jumping out a window, hoping to go up, you always land on your fanny, but hard. Action must grow out of love and concern for a sick person, based on a tough but kindly approach.

BASIC ASSUMPTIONS ABOUT ALCOHOLISM

1. Alcoholics are people; so are their wives and children!

2. Alcoholism is a disease, sickness, illness. It is other things, too!

Law enforcement problem	Economic problem
Legal problem	Welfare problem
Marital problem	Juvenile problem
Social problem	School problem

It is in these contexts most of you will see it, except if you are a nurse in an emergency room or hospital . . . then it is a medical problem. We shall not be limited by medical or psychiatric models of cause or cure.

3. We do not know its cause or causes. There are no universals - no always - no never.

4. Programs, policies or therapies which are predicated on an assumed knowledge of causation are doomed to failure and frustration with both alcoholics and their families.

5. Alcoholism or alcoholics are recognizable. The signs and symptoms are well known. The definition we accept as being most useful, "An alcoholic is a person who repeatedly creates problems with his drinking." We do not make a distinction between alcoholics and problem drinkers.

6. The course and progression of alcoholism is exquisitely predictable. We subscribe to the pregnancy concept – you can't be a little bit alcoholic.

7. The destructive consequences are not limited to the drinker. The devastating effects are equally as great in other family members or close associates.

8. Equal attention (time, money, effort and training) must be given to the non-alcoholic victims and their problems.

9. Alcoholics can and do recover - so can non-alcoholics!

10. All evidence suggests that the key to recovery lies in motivation – the drinker's desire to get well, for both the drinker and the spouse.

11. The experience of those who have accomplished a successful recovery tells us that the motivation was provided by some crisis or the cumulative effect of a series of crises too painful or costly to endure.

12. Every alcoholic who has found sobriety was <u>forced</u> by the painful consequences of his own behavior to find a way to live -- without alcohol. Forced not to quit drinking, but to make a choice between his drinking and something else important to him – his job, his family, his health, his life.

Every wife who has been freed from the destructive cycle of alcoholism has had to make difficult choices – her responsibility to make a choice is just as important (perhaps more) than the decision of the alcoholic.

ATTITUDES THAT FACILITATE OR HINDER THE TREATMENT OF ALCOHOLISM

by
Joan Curlee

Naturally, we desire to explain why people drink in an excessive addictive manner. In seeking a "cause" for this behavior, it is easy to fall into an exaggerated reductionism. For example, I know a psychiatrist who assumes that any alcoholic can be considered an "infantile personality", with all that implies about dependency problems, other difficulties in object relationships, sexual immaturity, and general ego inadequacy. If he deals with a patient who has a history of a drinking problem, he assumes that his patient exemplifies an infantile personality, and treats him accordingly.

Other well-trained and experienced people have stressed other sides of an alcoholic's personality. Some assume that all alcoholics are sociopaths, who experience no guilt except their remorse when they have to bear consequences of their behavior, and who feel no genuine responsibility toward anyone. Others insist that the most common difficulty with alcoholics is their guilt – that they are people who make exceptionally high demands upon themselves and suffer agonies when they are unable to live up to these demands. Some stress the self-indulgent, irresponsible behavior of alcoholics and assume that alcoholics must be confronted with the consequences of their behavior. Others, especially Karl Manninger (1938; view alcoholism as basically self-destructive, an attenuated suicide, reflecting strong guilt feelings, inward-turned aggression and despair.

Some have stressed the gregarious nature of alcoholics, and have described them as especially field-dependent, drawing their cues from their environment, especially the people around them. Yet a very sensitive, discerning book on alcoholism, is called the "Lonely Sickness" (Whitney, 1965).

Still others see the alcoholic's drinking as a search for a mystical experience. Writers as different as William James and the novelist Thomas Wolfe have portrayed the role of alcohol in men's search for a sense of unity with the infinite. One psychiatrist who has worked for many years with alcoholics says she has found that her patients had, at some time early in their drinking, experienced what she calls a "cloud nine" experience, or "hitting the jackpot", in the sense of an oceanic sense of unity with the universe, and that they continue to seek this in more and more drinking. Although with the young, drugs may be serving this mind-expanding quest more than alcohol, she feels that this search for a mystical experience is an important factor in most alcoholic drinking.

Another approach stresses the social learning factors that contribute to alcoholic drinking and attempts to correct this faulty learning.

SOME BUT NOT ALL

All these formulations help to explain the drinking of some alcoholics, but none applies to all

problem drinkers. In my work with alcoholics, both in diagnostic assessment and in treatment, one thing that has struck me with great force has been the diversity among these patients. It seems to me that any attempt to apply a blanket explanation to all patients who present the complaint of excessive, uncontrolled drinking leads to errors in understanding and treating these patients. What we need, instead, is flexibility and respect for this diversity that will enable us to see what a patient shows us, rather than looking for ways to fit him into an etiological, or causal, theory.

DRINKING ITSELF INTERFERES WITH TREATMENT

The characteristics that appear when an alcoholic seeks treatment may well be, at least in part, the result of his drinking patterns and the ensuing conflict with his environment and significant people in it. When the symptom is removed, two patients who seemed quite similar may present very different characterological pictures – pictures which would necessitate very different treatment approaches. Assessing the underlying pathology in an alcoholic who is still drinking is virutally impossible, even with the most sophisticated diagnostic methods, and may help to explain the errors implicit in simplistic, over-generalized explanations. We feel a need to treat something more basic than symptoms, but it is quite difficult to determine what that "something more basic" might be.

The assumption that when a patient's basic difficulties are resolved the drinking will take care of itself has the difficulty that addictive drinking seriously interferes with psychological treatment of underlying conflicts. In a survey conducted for the American Psychiatric Association and the National Association for Mental Health (Glasscote et al., 1967), 90% of the psychiatrists in the survey considered alcoholics to be "more difficult" or "much more difficult" to treat than other patients. In fact, 27% described them as "impossible" to treat. I suspect that most of these discouraged therapists were attempting to deal with fundamental pathology without giving much attention to the symptom – drinking – itself.

DRINKING BEHAVIOR AS A PRIMARY PROBLEM

The fallacy implicit in this approach becomes clear when we consider the fact that therapy necessarily involves a certain amount of anxiety which must be endured, at least long enough for it to be brought into the hour. Alcoholics, however, have learned a foolproof way of escaping anxiety; when they feel a twinge of anxiety, the remedy is readily at hand – not introspection or examination of possible transference implications of their uneasiness, but the bottle. A number of conditioning studies (cf. Solomon and Wynne, 1954) have shown the difficulty of extinguishing a well-learned avoidance response. Somehow with alcoholics an escape from anxiety-creating situations via the bottle must be prevented. In determining how this can be done, however, the diversity of the patients must be considered. Some can avoid the escape reaction by reliance upon Alcoholics Anonymous. Others can be helped to avoid this escape by use of Antabuse. For others, a period of hospitalization may be necessary to help them learn that they can tolerate anxiety for a time without any dire results. For others, still other methods must be used. But unless the drinking behavior is dealt with directly and as a primary problem, therapy will usually be fruitless. A drinking alcoholic simply cannot, as a rule, tolerate the stresses and strains of formal psychotherapy. When therapy has succeeded without any adjunct designed to limit the drinking, it is usually because there has been a relationship established that is strong enough to provide a control. But this is more difficult than we sometimes like to think.

WHO CAN HELP THE ALCOHOLIC?

Our emphasis on underlying pathology implies that only a psychiatrist, psychologist, or perhaps a social worker can really treat an alcoholic. This has a ring reminiscent of the statement one formerly heard frequently in Alcoholics Anonymous: "Only an alcoholic can help an alcoholic". But the statement is heard much less frequently in A.A. today, and Bill W., one of the founders of A.A., has implored, "Let's be friendly with our friends", and has urged A.A. members to utilize any treatment modality that might be needed or useful in a particular case. Perhaps he has gone beyond many professionals in recognizing the implications of the tremendous diveristy among alcoholics.

There is a great deal of evidence that people can and do recover without psychiatric attention to their underlying conflicts. Some of the people in A.A., for example, have made recoveries any therapist would be proud to see in his patients, without psychiatric attention. Psychiatric treatment for all alcoholics cannot be made available even if it were clearly the treatment of choice. Unfortunately, too, the attitude that alcoholics are somehow uninteresting has kept some of our most talented innovative people from wanting to work in this field.

HIDDEN ENVY OR COMPASSION?

If we are to treat alcoholics successfully, we must believe that recovery is possible – and that it is desirable. But it seems that clinicians find it especially easy to joke about alcoholism in a way that hints, at least, that they are not really sure they want to do anything about it. Think back, and see whether you can remember times when the alcoholic has been the special butt of jesting in your own conversations. Somehow, it just seems that drunks are especially funny, whether it's a character portrayed by W. C. Fields, a television character, or the patient in the ward. The problem, I think, comes from our tendency to identify an alcoholic's drinking with our own. To us drinking is associated with having a good time, relaxing, and enjoying oneself in general. So a patient whose main complaint is too much drinking seems to be a person who is especially carefree, who is especially devoted to having a good time. The clinician may fail to see the patient's real suffering and may harbour a lurking envy for this carefree fellow who can "do as he pleases". Most psychiatrists and psychologists have a strong orientation toward work and duty or they would never have achieved their professional status. The seemingly hedonistic alcoholic patient may represent an aspect of ourselves that we have repressed in our quest for professional competence, and there may be some unrecognized reluctance to interfere with the "fun" the alcoholic is having. This unacknowledged envy, however, can easily be transformed into dislike: "Why should this guy be able to do as he pleases, when I have to work my head off?" "Why should I try to help him?"

If one looks and listens more carefully, he will find that the alcoholic's drinking is not like one's own – that there is a desperate driven quality about it that completely separates it from moderate drinking for relaxation, pleasure or sociability. I have noticed this identification with the alcoholic especially in young clinicians – "You may see he's acting in self-destructing manner, but that's only clear to someone on the outside – he's having a ball!" But the alcoholic is not "having a ball". At some stage in his drinking, perhaps he did. But by the time he presents himself for treatment, or is brought in by someone, he is hurting. Whatever pleasure he may once have felt is now outweighed by the pain, despite the bravado he may assume. Recognizing this pain may help us to see the bravado as a pathetic attempt to maintain some semblance of dignity. Eventually, we become capable of a compassionate view of the alcoholic, not one of hiden envy or dislike.

A FLEXIBLE APPROACH

What, then, are the attitudes that are necessary for successful treatment of alcoholics? Our approach must be diversified and flexible, recognizing the vast range of personality organization and types of pathology that may find expression in excessive drinking. We must be pragmatic, adjusting our approach to the realities of the situation, and making the best possible use of all available modalities for helping alcoholics. We must be inquiring and innovative, realizing that it is an interesting problem, deserving our best efforts. And we must be compassionate – not in a "bleeding heart" or "do-gooder" sense, but in the truest sense of empathy, of feeling with our patients. With these attitudes, and with our fullest utilization of our best clinical skills, alcoholism can be treated, and it must be.

HIGH RISK GROUPS

Research and statistics indicate the findings that there maybe a genetic or an environmental susceptibilty to alcoholism. Although one out of ten drinkers in the United States is believed to be alcoholic, ethnic group ratios seem to greatly differ. Less than 1% of Jews are believed to be alcoholic but 80% of the Indians and Eskimos who drink become alcoholic. The Italian drinking population has twice the rate of alcoholism as do the Irish and Northern Europeans.

There is statistical evidence that children of alcoholics have at least four times greater risk than the average population for acquiring alcoholism. Studies report that if one parent is alcoholic there is a 50% greater risk of the children becoming alcoholic and 80% higher risk if two parents are alcoholic. Children who are raised in a teetotalling or non-drinking home are also at high risk for acquiring alcoholism.

Women, blacks and the elderly are also considered higher risk, possibly due to recent recognition of the disease in a greater number of individuals. If prevention of the disease is possible, then higher risk populations would benefit from early educational efforts. Because a significant percentage of the total population is directly affected and society at large is indirectly affected, earliest identification and treatment for problems of and related to the disease remains our primary goal.

FACTS

(1) Total population in the United States = approximately 200,000,000 people.

(2) Approximately 50% of the United States population drink.

(3) One out of ten drinkers will become alcoholic.

(4) One alcoholic will directly affect four other people.

(5) 50,000,000 people are affected by alcoholism.

(6) Therefore, 25% of the population will be directly affected or afflicted by the disease of alcoholism.*

(7) Family may be directly affected by loss of job, family violence, emotion abuse, related health problems, legal problems, social ostracism, etc.

(8) Society may be affected by loss of quality and quantity performance of the worker, by traffic and safety violations resulting in personal or property damage, by crime and delinquency rates which directly correlate, etc.

(9) Include cost of alcholism vs. cost of treatment.

*Add to these figures the growing number of those with Chemical Dependency involving other drugs.

WARNING SIGNS

#1 Drinking or using drugs that causes others to become worried or concerned.

Adult

1. "My wife looks nervous or upset whenever I pour another drink at home. Sometimes I wonder if she's crazy, or if I'm in trouble."

2. "My drinking heavily has really affected my blood pressure. My doctor prescribes more medication thinking I'm tranquilizer deficient. Now at least I can cut down on booze by taking more pills. I don't worry about anything now."

Teen

1. "Mom calls me a lush and Dad is always waiting in the dark living room with just that light of his burning cigarette - waiting for me to crawl in the back door, drunk again!"

2. "Tom, my brother, worries about how much I spend on drugs and says I'm messed up. I worry too when I can't get high as easy as before."

#2 Drinking or using drugs that affect your reputation.

Adult

1. "Everybody else thinks I'm the life of the office party, except that turkey boss of mine. Imagine, barring me from the next office party just for my use of a few choice and well deserved words."

2. "As a nurse, I don't really appreciate having my pupils analyzed or all the supervision I get while setting up my hospital medication tray. It's none of their business what drugs I use in my time off work."

Teen

1. "Friends just drift away. Boyfriends are always taking care of me when I get sick or stoned, but they all get tired of me too soon."

2. "I thought I'd be smoother asking for a dance if I was pretty tanked, but when I opened my mouth to ask, it was too late. She didn't appreciate my lunch on her shoes. She did appreciate them carrying me out."

#3 Drug related behavior that can cause harm to another or become an embarrassment.

Adult

1. "I really love my kids but Saturdays and Sundays are my days too – to have a few drinks and just relax. I feel bad breaking promises to do things with them, but they're too young to enjoy my kinda fun. They got smart and quit asking. They don't come near me now."

2. "My wife really embarrasses me to tears. That's the last time I bring home somebody for dinner to find her in that ratty robe with a cocktail and frozen dinners. She cries, and 'I' have to do the explaining."

Teen 1. "The golden boy wonder of the family was finally to graduate and all the relatives were there. The pre-party was the best part, but I was too stoned to take those stairs up to the stage."

2. "I came to the party with one guy, drank with another, and left with a carload of guys I didn't even know. I feel like screaming 'No' that wasn't me."

#4 Lying or minimizing about your drinking or use of drugs.

Adult 1. "I tell my husband about having a glass of wine before he gets home, but I refuse to mention the quart of bourbon I down while watching the soaps. He's so blasted critical."

2. "My job gave me the ulcer and all I take is stomach tranquilizers that doc gave me. I keep telling the boss to lay off the load and the doc is getting touchy about refills. It says "take as needed" on the label, and I need a lot more tranquilizers now."

Teen 1. "My folks were okay with my drinking, so I told them that dope scared me. Scared me so much I used them at a friend's house."

2. "I never have more than a couple; first, a couple of shots, then a couple of six packs, then . . ."

#5 Drinking or using more of a drug than planned.

Adult 1. "The bar's last call, and 'now' she calls me. That wife of mine really has nerve to call me here and tell me I was to be home at 7:00 p.m. She doesn't understand how I feel about stopping after a couple of drinks."

2. "I don't care if I did tell you not to give me the keys! I can walk and talk while high, so I can certainly drive as good, maybe even better than usual."

Teen 1. "All I wanted to do was get loosened up before the prom. I bet it was the mixing of drinks that made me pass out."

2. "I loved drinking, and grass was really safe, but speed wasn't. Then speed was okay, but L.S.D. was bad; then L.S.D. wasn't too bad, but . . . then, I got scared to death."

#6 Trouble at school, work, or with the law due to drinking or using drugs.

Adult 1. "I thought it was pretty funny the night I got stoned and the cash register went so slow. The boss failed to see the humor."

2. "Good thing cops are a sucker for a pretty face and the water works. My husband would kill me, at the least, if I got another D.W.I."

Teen 1. "When you start off the day with geometry it helps to get stoned before class. I'm flunking the course anyway."

2. "Got my second M.I.P. last night and the lousy cops brought me home. Now Dad's trying to ground me. I'm not planning on missing that kegger this Friday, no matter what happens."

#7 Using alcohol or other drugs to deal with stress.

Adult 1. "While retired, the days are too long and too lonely. A drink is a dependable friend. Sipping sherry has warmed my hours."

2. "Bill and I fought so much that my nerves were shot 'til Valium saved the day. After the last baby, I found another doctor to prescribe another little wonder drug to help get me through the day."

Teen 1. "Finals week means getting a hold of plenty of speed, just to make it through. With a kegger after finals, I can come down easier."

2. "Burger King isn't my idea of a job with promise. It's a real bummer and you'd drink too if you had to work there."

#8 Changing to friends who drink or use drugs more often.

Adult 1. "The girls at my bridge party were BORING! Now, I go out with the office crew to bar hop, and call hubby to get dinner and watch the kids. If he's so interested in conservation and domestication – he can have it."

2. "Some promotion, sitting in an office with a bunch of straights who never get high. Told the boss I couldn't hack the job. Back in the shop, at least now on break time I can get away with smoking grass to enjoy my job."

Teen 1. "Yah, I used to hang out with that crowd, but now me and my friends go to the bars."

2. "Our group is dedicated to getting high. No room for lightweights in our group."

#9 Family relations and responsibilities slipping or endangered due to drinking or using drugs.

Adult
1. "I refuse to go to the in-laws anymore. Celebrating by drinking is traditional. They get ticked whenever I bring a bottle, so I'd rather not go."
2. "I wanted to be 'friend' to my kids, and I've been smoking marijuana longer than they have. Now, they get all upset with me and won't even join me when I offer them the stuff for free."

Teen
1. "My folks don't care or love me even a little bit. They hassel me, ground me, dropped my car insurance, threatened me – just everything! I may take drugs but they smoke cigarettes and drink."
2. "Last night, while babysitting, I drank all their wine. They told me to help myself to anything I needed."

#10 A change in personality or behavior when drinking or using drugs.

Adult
1. "I remember that wedding reception last night but today my wife hands me this riot act about my foul mouth and making a fool out of myself. She must have been with another guy."
2. "All the other girls have complimented me on the change in my appearance and boundless energy. Those diet pills are really working.

Teen
1. "At first, my girlfriend liked the mellow change in me when I was stoned. I could space off anything. One night I spaced "her" off and left her at the party. Joe drove her home and now she claims she doesn't care if she ever sees "mellow me" again."
2. "I needed to gain some weight before football season arrived. I could put away more beer than anyone else and now that I can put away a case a night I'm up to 210 pounds. A bit bombed, and 50 pounds heavier, I can still perform a balance act on any bridge railing. For a guy who felt like a failure, I can do anything when half tanked."

AM I DRINKING TOO MUCH? THE NINE SIGNS OF ALCOHOLISM.

1 – INCREASE IN ALCOHOL TOLERANCE.

"I can drink them all under the table."

2 – OCCASIONAL OR PARTIAL MEMORY LAPSES

"Did I really do that last night?"

3 – DRINKING BEYOND ONE'S INTENTIONS

"Boy, did I get smashed! Should have eaten something.

4 – INCREASED DEPENDENCE UPON ALCOHOL

"Can't wait . . . got to have a quickie."

5 – SNEAKING DRINKS

"Needed that extra one . . . who's to know?"

6 – PREOCCUPATION WITH ALCOHOL

"Election day tomorrow . . . better pick up a bottle."

7 – RESENTFUL WHENEVER ONE'S DRINKING IS DISCUSSED.

"It's none of their business . . . I can handle it."

8 – FUTILE, FRUSTRATING WATER-WAGON ATTEMPTS.

"This time I've got to do it . . . just got to!"

9 – RATIONALIZING LOSS OF CONTROL.

"If they had my problems, they'd drink, too."

IF YOU HAVE ONE OR MORE OF THESE SIGNS, YOU MAY HAVE A DRINKING PROBLEM AND SHOULD SEEK TREATMENT.

CHEMICAL DEPENDENCY UNIT

PART II

The Family

Part II - The Family

Teacher Guide . . . . . .II, 1-2
Decision-Making & Coping Skills . . . . . .II, 3
Scenarios . . . . . .II, 4
Situations for Problem Solving . . . . . .II, 5
Responsible Decisions Activity . . . . . .II, 6-8
Listening to Myself Activity . . . . . .II, 9
What Can You Do With Two Bucks? . . . . . .II, 10
Early Warning Signs for the Family . . . . . II, 11-14
Alcoholism: The Family - Readings . . . . . II, 15-18
Homework/Discussion Questions . . . . . .II, 19
Film Guide for "Stoned" . . . . . II, 20-26
Self-Esteem Evaluation . . . . . .II, 27
You Are Coping If . . . . . .II, 28
Guidelines to Help Others . . . . . .II, 28
Fetal Alcohol Syndrome (FAS) . . . . . .II, 29
FAS Activity Sheet . . . . . .II, 30
Teachers' Resource Material
The Recovery of Chemically Dependent Families . . . . . II, 31-35
Children Held Principals . . . . . II, 36-39
The Effect of Parental Alcoholism on Adolescents . . . . . II, 40-47
Love is Destroyed . . . . . II, 48-50
The Alcoholic's Weapons . . . . . II, 50-51
Self-Concept . . . . . II, 52-53

Part II – The Family

Teacher Guide

TEACHER PREPARATION – Read P. II,31-53 of this section.

Day 1 – A. Distribute "Decision Making Skills" sheet (P. II,3-Student Handout) and discuss. This model can be used to help students deal with problems of peer pressure to use alcohol/drugs or pressure to be with others who are using.

B. Read each "Scenario" (P. II,4) and ask class to use "Decision Making" model in giving solutions to problems presented.

C. Assign: Do "Suggested Situations For Problem Solving" (P. II,5) in same way as above, writing the solutions.

Day 2 – A. Discuss homework.

B. Distribute and briefly discuss "Listening to Myself" (P. II,9-Student Handout). Then assign as homework. Use "Two Bucks" sheet (P. II,10) to promote discussion, relating to decision making.

C. Lecture and ask students to take notes on "Early Warning Signs For Family Members" (P. II,11-14).

D. Discuss (or assign students to read about) the 5 major survival defense mechanisms of the family members (from "Alcoholism: The Family," P. II,15-18).

E. Assign reading of "Alcoholism: The Family" and completion of "Listening" sheet.

Day 3 – A. Discuss completed "Listening" sheets.

B. Continue discussion of family problems caused by chemical dependency, reviewing the Survival Mechanisms for family members.

C. Show film "The First Step" (30 minutes). The students should be asked to determine who in the family is alcoholic and be able to identify the Early Warning Signs. The film illustrates that the 5 survival roles can be adopted by different people at different times and that a single person can play many different roles. The students should be able to see, too, that each person plays a different role, depending on the different alcoholic that he/she is relating to.

D. School counselor speaks to students to encourage them to seek assistance for problems related to chemical dependency.

E. Assign: "Homework/Discussion Questions" (P. II,19) as homework.

Day 4 – A. Use "Homework/Discussion Questions" (P. II,19) to review and discuss the film "The First Step"

Day 4 (Continued)

B. Distribute "Self-Esteem Evaluation" & ask students to complete in class. Discuss the inventory and tell students how to score it.

1. Total all ODD statements.
2. Total all EVEN statements.
3. Subtract EVEN total from ODD total.
4. Perfect score would be 39.

or

Best answers are:

1.3
2.0
3.3
4.0
5.3
6.0
7.3
8.0, etc.

Evaluate your strengths and weaknesses based on the closeness of each answer to the "best answer."

C. Encourage students to set a personal goal of raising self-esteem. Distribute "You Are Coping If" sheets (P. II,28-Student Handout).

Day 5 – A. Show videotape "Stoned." (40 minutes)

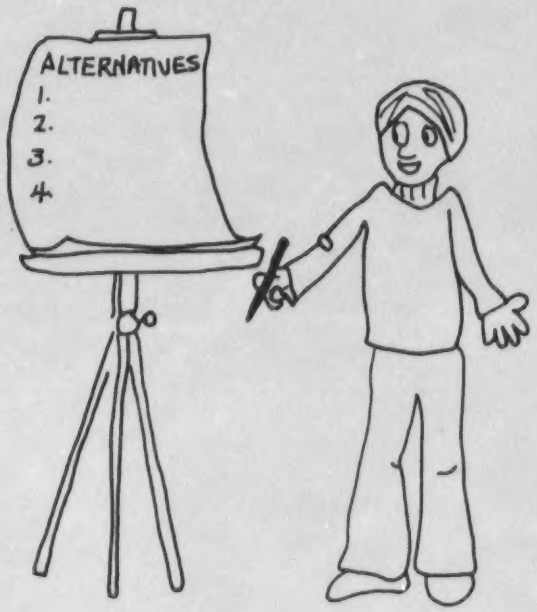
B. Discuss, using material provided (P. II,20-24).

C. Assign: Quiz on Part II (Early Warning Signs for Family and Survival Defense Mechanisms for Family Members)

DECISION-MAKING AND COPING SKILLS

1. Admitting a problem exists and facing it.
2. Defining the problem and who owns it.

3. Listing alternative solutions to the problem.



4. Predicting consequences for yourself and others.
5. Identifying and consulting sources of help.

6. Giving help to others when needed and wanted.
7. Experimenting with a solution and evaluating the results.

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SCENARIOS

1. Your father has been drinking heavily and is about to drive your mother to do some grocery shopping. It is 9 p.m., and the roads are still icy from the previous day's snowstorm. She has no license and there is no food in the refrigerator. What could you do? What would you do? Why?

2. You are at a party and your best friend has just accepted a ride home from another friend who is drunk. No one else lives near. You have no license and no money, and you know your friend doesn't have much money. He lives 2½ miles away. It is a cold winter night, around 11:30 p.m. What could you do? What would you do? Why?

3. Your 17-year-old sister has a date with her boyfriend. You just let him in the door, and he's obviously drunk since he knocked over a lamp trying to sit down and has talked only nonsense. You go upstairs and tell your sister he's drunk, and she tells you to mind your own business. You know they are going in his car to a party way on the other side of town. Your parents are next door with friends. What could you do? What would you do? Why?

4. You are hitch-hiking to school because you are already late for first period. A nice looking, middle-aged lady in a station wagon offers you a ride, so you get in. You are sitting next to her in the front seat, and you can smell whiskey on her breath. In the back are her two small children and a dog. What could you do? What would you do? Why?

5. You're driving home from a party, giving your best friend a lift home first. You simply don't believe you're drunk even though you had a lot to drink at the party. You feel perfectly capable of driving. You've had one DWI before. What could you do? What would you do? Why?

6. You know you have already had a little too much to drink at the kegger as you drive your friends to the concert. You don't want to stop driving because you desperately want to show off your new Fiat. On the other hand, you don't want to damage it in an accident or lose your license to operate it. If you can find a good excuse, you are willing to pull over, lock the car and hitch, but no one is going to replace you at the wheel of your new car. What could you do? What would you do? Why?

SUGGESTED SITUATIONS FOR PROBLEM SOLVING

1. Your parents are getting a divorce.

2. Your best friend is moving out of state.

3. Your sister is using drugs.

4. Your dad says you have to pay your own tuition to school next year, and you can't get a job.

5. Your friend is accused of cheating on a test, and you know he didn't.

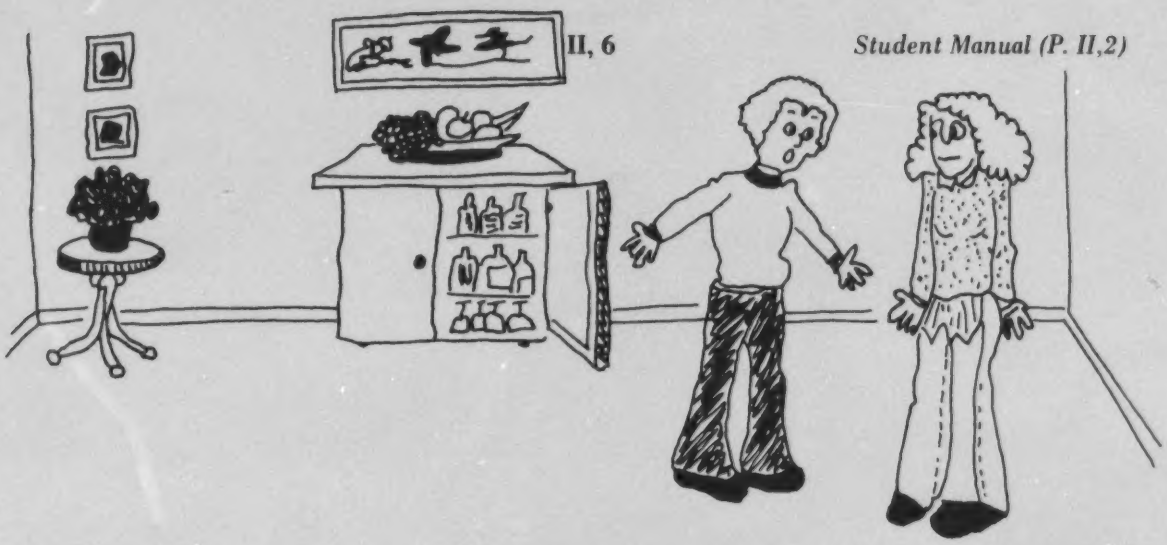
6. You were in the girls' bathroom and other girls were smoking when a teacher found out. One girl was expelled and no one else was caught.

7. Your dad was fired for being repeatedly late for work.

8. A boyfriend of yours comes home with you to do homework. You walk in on another of your mom and dad's arguments.

9. Your favorite teacher backs his car into another teacher's car. He dents the bumper and leaves the scene of the accident while you're watching.

10. You and a friend meet another student who says he can sell you any kind of dope you want to buy.



Read the following situations. Check in the appropriate space whether you think the decision about drinking described in the situation is responsible or irresponsible. Then explain briefly why you answered as you did.

THE SLUMBER PARTY

1. Ann is spending the night at Cathy's house. Cathy is 17, and her parents are away for the week-end. Ann notices the well-stocked liquor bar and suggests that they make themselves a drink.

   Responsible _____ Irresponsible _____

   Why?

2. Cathy refused, knowing that her parents would not approve.

   Responsible _____ Irresponsible _____

   Why?

3. Ann begins to tease Cathy about being a coward and even offers to take the blame if they are caught.

   Responsible _____ Irresponsible _____

   Why?

4. Cathy pours a drink for Ann but not for herself.

   Responsible _____ Irresponsible _____

   Why?

Read the following situations. Check in the appropriate space whether you think the decision about drinking described in the situation is responsible or irresponsible. Then explain briefly why you answered as you did.

THE WEDDING RECEPTION

1. Eric, 20 years old, invites Jean who is 18 to his sister's wedding. The groom's father proposed a toast to the happy couple with a glass of champagne.

   Responsible _____ Irresponsible _____

   Why?

2. Eric's 15-year-old sister, Debbie, is poured a glass of champagne, and she drinks it.

   Responsible _____ Irresponsible _____

   Why?

3. For the wedding reception there are two kinds of punch - one with liquor and one without, but they both look the same.

   Responsible _____ Irresponsible _____

   Why?

4. Aunt Dorothy does not drink alcoholic beverages. Eric, as a joke, serves her a cup of the punch that contains alcohol, and Aunt Dorothy drinks it.

   Responsible _____ Irresponsible _____

   Why?

5. Miss Coleman who sang during the wedding ceremony is getting "high" on the punch that contains alcohol.

   Responsible _____ Irresponsible _____

   Why?

THE WEDDING RECEPTION (Continued)

6. Paul Benson, the best man, has had more cups of the punch containing alcohol that he can count. He is getting loud with his funny jokes and spilling cake crumbs on the carpet. He asks Debbie to bring him another cup of punch.

   Responsible _____ Irresponsible _____

   Why?

7. Debbie gets him another cup of punch.

   Responsible _____ Irresponsible _____

   Why?

8. Eric appears sober, although Jean knows that he's had four cups of the punch containing alcohol within the past hour and one-half. He has to drive her home. He asks her to pour him one more cup "for the road."

   Responsible _____ Irresponsible _____

   Why?

THE KEGGER

1. Rick and Heather, both 18, decide to go to the Friday evening kegger.

   Responsible _____ Irresponsible _____

   Why?

2. Rick drinks beer, while Heather opts for a soft drink.

   Rick Responsible _____ Irresponsible _____
   Heather Responsible _____ Irresponsible _____

   Why?
   Why?

3. Feeling that Rick has had a little too much, Heather offers to drive him home.

   Responsible _____ Irresponsible _____

   Why?

4. Not wanting anyone else to drive his car, Rick refuses.

   Responsible _____ Irresponsible _____

   Why?

LISTENING TO MYSELF

DIRECTIONS: List 10 things you really love to do. Then mark yes or no for each category.

1.	2.	3.	4.	5.	6.	7.	8.	9.	10.	. . . THINGS I LOVE TO DO!
										1. Costs $2 or more each time
										2. Done primarily alone
										3. Done primarily with others
										4. School - or job-related
										5. Can still do this after age 40
										6. Requires good health to do
										7. Done when I am already happy
										8. Date I last did this activity
										9. Activity requires alcohol or another drug to enjoy
										10. My parents do this activity
										11. My parents did not do this activity
										12. Done primarily when I'm depressed

WHAT CAN YOU DO WITH TWO BUCKS?

What can you do with $2 other than buy a six pack?

You can . . .

Play 8 games of foosball

Play 12 games of pinball

Bowl 2 games

Eat . . .

Go to a movie

Go visit art displays

Go visit community art gallery

Write 11 letters

Go to the movies

Make a long distance phone call

Cruise around on $2 worth of gas (Editor's note: We realize that by the time this is printed $2 worth of gas might not get you very far. This is only an option for people who drive Diesel Rabbits or Mopeds!)

Buy 13 boxes of cracker jacks and play with the prizes

Build a snowman – then buy 2 hot chocolates and six donuts

Go to church and donate $2

Give yourself a perm

Paint by numbers

Play 8 games of pool

Go to a women's basketball game

Go to a men's basketball game

Play ping pong for 1 hour and 40 minutes

Go to a play or concert

Play poker with a $2 limit

And . . .

OACA Omaha Area Council on Alcoholism
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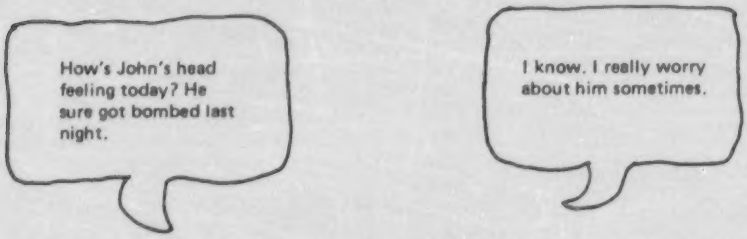
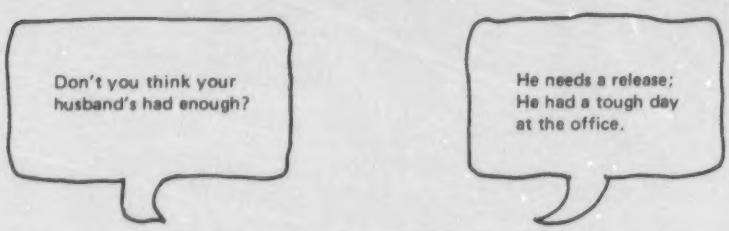
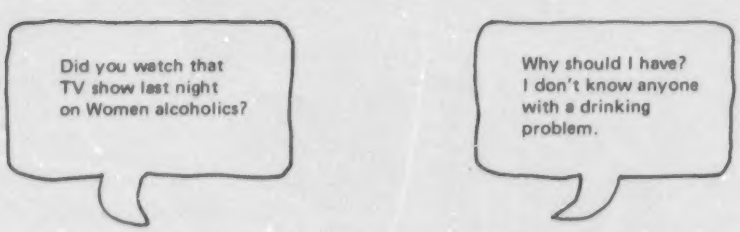
EARLY WARNING SIGNS FOR THE FAMILY



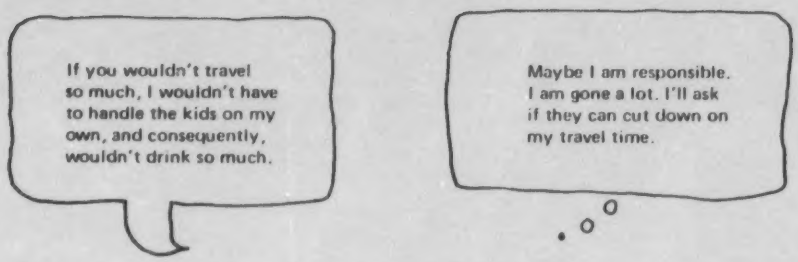
OCCASIONAL DOUBTS ABOUT ALCOHOLIC'S DRINKING



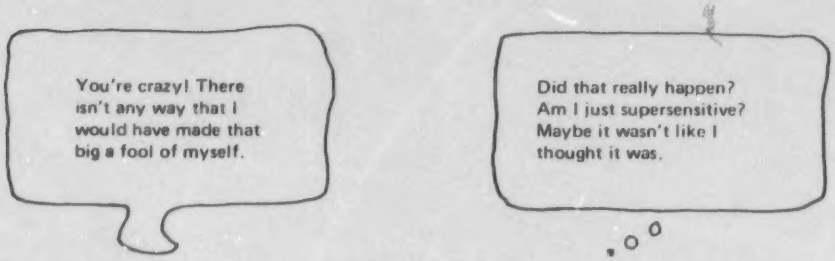
RATIONALIZES ALCOHOLIC'S BEHAVIOR



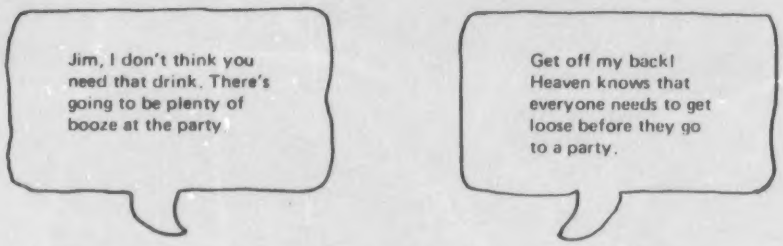
UNABLE TO DISCUSS THE PROBLEM


If you wouldn't travel so much, I wouldn't have to handle the kids on my own, and consequently, wouldn't drink so much.
Maybe I am responsible. I am gone a lot. I'll ask if they can cut down on my travel time.

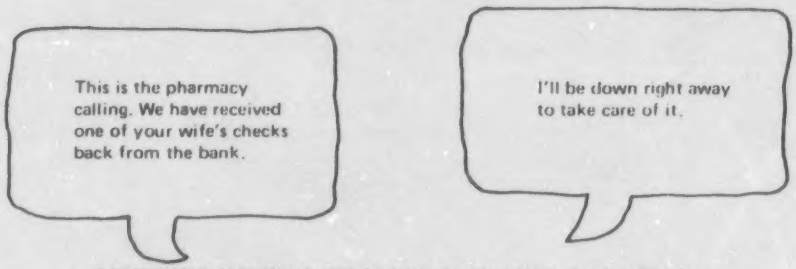
FEELS GUILTY AND RESPONSIBLE FOR THE ALCOHOLIC'S DRINKING


You're crazy! There isn't any way that I would have made that big a fool of myself.
Did that really happen? Am I just supersensitive? Maybe it wasn't like I thought it was.

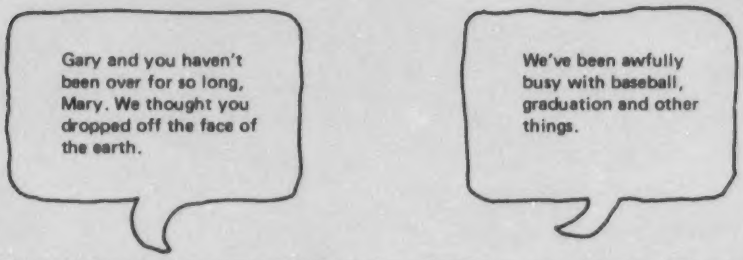
BEGINS DOUBTING OWN PERCEPTIONS AND MEMORY


Jim, I don't think you need that drink. There's going to be plenty of booze at the party.
Get off my back! Heaven knows that everyone needs to get loose before they go to a party.

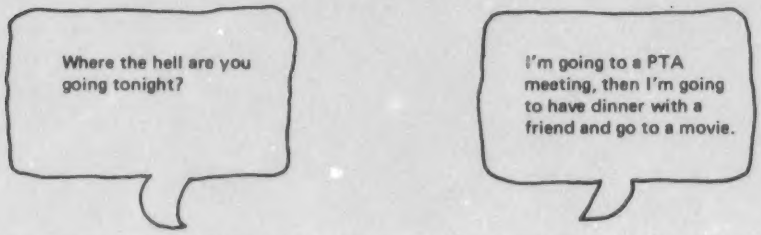
CONSTANTLY CRITICAL AND NAGGING IN AN ATTEMPT TO CONTROL ALCOHOLIC'S DRINKING


This is the pharmacy calling. We have received one of your wife's checks back from the bank.
I'll be down right away to take care of it.

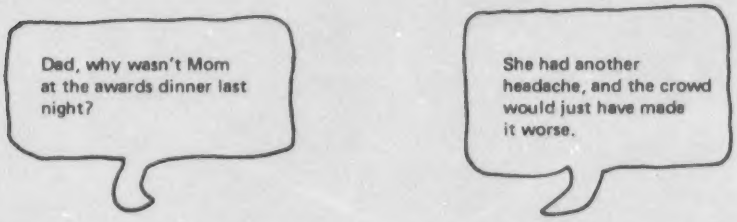
ASSUMES RESPONSIBILITY FOR THE ALCOHOLIC


Gary and you haven't been over for so long, Mary. We thought you dropped off the face of the earth.
We've been awfully busy with baseball, graduation and other things.

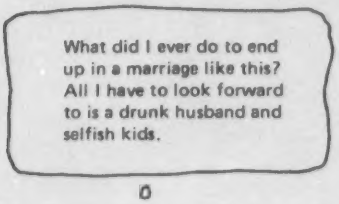
AVOIDS FAMILY AND FRIENDS BECAUSE OF ALCOHOLIC'S DRINKING



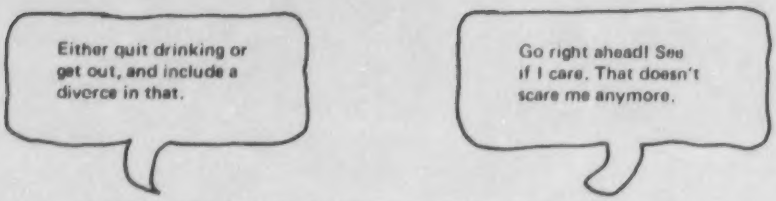
BECOMES OVER-INVOLVED IN OUTSIDE ACTIVITIES TO AVOID ALCOHOLIC



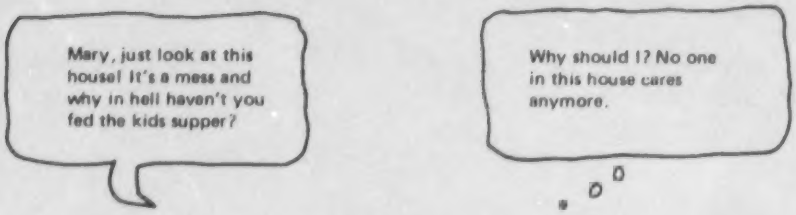
MAKES EXCUSES TO FAMILY AND FRIENDS TO COVER FOR ALCOHOLIC'S DRINKING



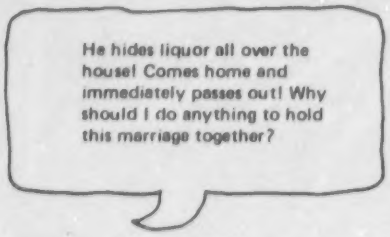
EXPERIENCES SELF-PITY



MAKES IDLE THREATS BECAUSE OF DRINKING


Mary, just look at this house! It's a mess and why in hell haven't you fed the kids supper?
Why should I? No one in this house cares anymore.

BECOMES IMMOBILIZED AND DISINTERESTED BECAUSE OF ALCOHOLIC'S DRINKING


He hides liquor all over the house! Comes home and immediately passes out! Why should I do anything to hold this marriage together?

BECOMES TOTALLY OBSESSED WITH ALCOHOLIC'S DRINKING

You can see what the drinking is doing to the alcoholic, can you see what it's doing to you!

Alcoholism is a family disease. It affects the spouse as much as it affects the alcoholic. The family can be helped.

For more information, Call 345-4080

Omaha Area Council on Alcoholism
2222 California Street
Omaha, Nebraska 68102

ALCOHOLISM: THE FAMILY

Alcoholism is a progressive family disease. Each person that is close to an alcoholic learns to adjust, readjust and maladjust. The family becomes increasingly caught up in protecting the alcoholic, disguising the alcoholic's problem, and assuming responsibility for the alcoholic's behavior.

As the family adapts to the alcoholic's behaviors, they become distressed. They learn to protect and disguise their own feelings with a very specific set of defenses.

Each person within the family masks his/her feelings by taking on a role. These roles are known as survival defense mechanisms.

Survival defense mechanisms are an essential element in the family disease of alcoholism. The mechanisms result from a civil war within an individual because of an inconsistency between his/her feelings and his/her behavior.

The alcoholic is often unaware of the progressive nature of the disease because of increased tolerance, loss of control, and unrealistically looking at himself/herself. The family is just as unaware of their readjustment to the progressive nature of the disease because of similar unrealistic self-perception.

There are five major survival defense systems. They are:

The Chief Enabler – is usually the closest emotionally to the chemically dependent person and offers the family a sense of responsibility. The civil war arises between feelings of hurt, anger, pain, and guilt conflicting with defenses of fragility, self-pity, super responsibility, manipulation, self-blaming, and powerlessness.

The Family Hero – is usually the first child or the only child. The Family Hero offers the family self-worth. The primary feelings of the Family Hero are loneliness, hurt, inadequacy, confusion and anger. The primary defenses are super responsibility, appearing all together, specialness, successfulness, works hard for approval, develops an independent life away from the family. The Family Hero later in life tends to marry a chemically dependent person.

The Scapegoat – offers the family a focus away from the behaviors of the alcoholic. The primary feelings of the Scapegoat is hurt. Other feelings involved are: loneliness, anger, fear, rejection. The defense system includes: strong peer value, withdrawness, unplanned pregnancy, defiance, acting out, sullenness and chemical use. A high number of teenage suicides occur among teenagers who have been the Scapegoat in the family system.

The Lost Child – offers the family relief. The Lost Child is primarily the one who appears okay. The Lost Child is resigned to being a loner and believes himself/herself to be unimportant. The feelings involved with this child are: loneliness, hurt, inadequacy, and anger. The Lost Child surrounds himself/herself with a wall of defenses including quietness, distance, super independence, rejection, aloofness and withdrawing. Often the Lost Child is overweight, finding consumption of food another way to protect his/her feelings. The Lost Child also will avoid intimacy in relationships with others.

ALCOHOLISM: THE FAMILY (Continued)

The Mascot – offers the family humor, and tends to be the youngest child. Often the Mascot is hyperactive under stressful situations and has been misdiagnosed as hyperkinetic. He/she often feels more than he can verbalize. The primary feelings are: fear, insecurity, confusion, and loneliness. These feelings conflict with the defenses of: humor, fragility, always being super cute, clowning, and doing anything to attract attention. The Mascot will use humor to avoid a stressful and tense situation.

These defense systems can appear in different family members at different times. One person can adopt more than one role. The family members will continue in these roles whether the alcoholic remains in the family or not.

The most important factor in healing the family system and stopping the progression of the disease is to eliminate the civil war between feelings and behaviors within each survival defense system.

–Alcoholism is a treatable disease.

–Family members can be helped to eliminate the civil war within themselves.

–For more information call or write:

Omaha Area Council on Alcoholism
2222 California Street
Omaha, Nebraska 68102
345-4080

THE HOME TREATMENT

Many people, without understanding alcoholism, seek through various ways to get the alcoholic to do something about his/her drinking. These ways are so common they have become known as the "home treatment."

1. "Don't you love me?" "If you really love me and the children, you would do something about your drinking."

   Result: If the alcoholic has already tried to stop on his/her own, this approach by the family just intensifies the sense of guilt and failure. The alcoholic will no doubt feel lonely and rejected – and still will not be able to stop drinking.

2. "Why don't you act like a man? Use your willpower."

   Result: This lack of knowledge of alcoholism as a health problem just increases the alcoholic's sense of inadequacy and failure. This approach is as useful as telling a cancer patient to cure himself or herself with "willpower."

3. Coax him/her not to drink and ask for promises.

   Result: The alcoholic is able to make, but usually not keep, promises of this sort. Asking the alcoholic to cure himself or herself keeps the myth alive that alcoholics can make themselves better without any outside help. When the alcoholic fails to keep the promise, the family loses even more trust and the alcoholic's sense of failure and guilt increase.

4. Hide or destroy the supply of alcohol.

   Result: Often the family games of lying and dishonesty are perpetuated by hiding the supply. The trust and open communication that are necessary if things are to improve are not possible. It is pointless to try to prevent an alcoholic from drinking.

5. Threats.

   Result: If the threats are made repeatedly and not followed through by the family, the alcoholic simply learns that he/she doesn't have to face the consequences of the drinking. The alcoholic will lose respect for the family and pay little attention to what is said.

Usually other factors that are not helpful come into the picture too. A "holier than thou" or "martyr like" attitude isn't healthy for the family or for the alcoholic. Sometimes the family member will even try to drink with the alcoholic in an attempt to control the alcoholic's drinking.

If all of this is to be avoided, what can the family do?

First, it is important that they talk about their problems with someone outside of the family, someone with knowledge about alcoholism. Doing so will provide the opportunity for the family members to talk about their feelings while coming to a necessary understanding and acceptance of alcoholism, powerlessness and the disease.

ALCOHOLISM RECOVERY FOR THE FAMILY

The place to begin in helping an alcoholic recover is with yourself. Learn all you can. Put it into practice, not just into words. This will be far more effective than anything you attempt to do for him or her.

There are several rules of thumb which may be observed:

1. Learn all the facts and put them to work in your own life. Don't start with the alcoholic.

2. Attend AA meetings, Al-anon meetings, and if possible go to a mental health clinic, alcoholism information center or to a competent counselor or advisor who has experience in the field. GO YOURSELF, don't send the alcoholic.

3. Remember that you are emotionally involved. Changing your attitude and approach to the problem can speed up recovery.

4. Encourage all beneficial activities of the alcoholic and cooperate in making them possible.

It is easier to find a list of dont's in dealing with alcoholics, for it is easier to understand why you fail than to know why you succeed. The following list is not conclusive, but it makes a good beginning.

SOME DONT'S:

1. Don't allow the alcoholic to lie to you and accept it for the truth, for in so doing you encourage this process. The truth is often painful, but get at it.

2. Don't let the alcoholic exploit you or take advantage of you, for in so doing you become an accomplice in the evasion of responsibility.

3. Don't let the alcoholic outsmart you, for this teaches him to avoid responsibility and lose respect for you at the same time.

4. Don't lecture, moralize, scold, praise, blame, threaten, argue when drunk or sober, or pour out liquor. You may feel better but the situation will be worse.

For more information call:

The Omaha Area Council on Alcoholism
345-4080

HOMEWORK/DISCUSSION QUESTIONS:

The Home Treatment.

1. Read through the common "Home Treatments".
   Are any of these connected to the early warning signs for the family? If so, how?
2. Re-state each of the five items in a sentence or two using YOUR OWN WORDS.
3. Why might some family members try drinking with the alcoholic?
4. Why is it important for a family member to talk to someone outside the family? How was this important in the film "The First Step"?

Alcoholism: The Family

1. What causes the civil war that exists inside each family member?
2. Which role uses humor as a way of coping with situations?
3. Which role tries to appear exceptionally responsible and together?
4. Which role shows the highest rate of suicide?
5. Which role seems to be the quietest and most withdrawn?
6. Which role is usually emotionally closest to the alcoholic?
7. What is the most important factor in helping the family?
8. Is it possible for each person in the family to play more than one role?
   In the film, what roles did the son play?
   Give examples.
   What roles did the daughter play? Give examples.
   What roles did the mother play? Give examples.

Alcoholism Recovery for the Family

1. What is the first thing a person who is concerned about someone's drinking should do?
2. List two actions that a concerned person can take.
3. Why might a change in attitude be important?
   Which early warning signs for the family might a change in attitude counteract? How?
4. Which of these guidelines did Bob, the son in the movie, follow?
   Give examples.

A FILM IS INCLUDED WITH EVERY LCA PRINT. You may make as many copies as you need but please return guide to film can for the next user! Additional copies may be obtained free from: LCA Customer Service Dept., 1350 Avenue of the Americas, New York, NY 10019/Tel. (212) 397-9360.

STONED
An Anti-Drug Film

(Full version: 50 minutes/sale $625/rental $50/LC No. 80-701730)
(Edited version: 30 minutes/sale $450/rental $40/LC No. 80-701731)
Starring Scott Baio, Vinnie Bufano and Largo Woodruff
(Inspired by Maia Wojciechowska's Tuned Out, from Harper & Row)

GRADE LEVEL: 7-12

CURRICULUM AREAS: Sociology, Psychology, Drug Information, Language Arts, Values, Family Living

SUMMARY: One of the primary needs of adolescence is to have a positive sense of identity. Often that identity is supplied by joining a group of one's peers. The problems one teenager faces in fulfilling this need is explored in this film. Jack Melon is too shy to have formed any meaningful relationships with others his age, and has filled this gap by idolizing his older brother, Mike. Jack is totally dependent on his athletic, outgoing, confident brother. With Mike, Jack is sure of himself and feels accepted. Mike even seems to enjoy Jack's corny riddles.

When Mike inevitably explodes in frustration at Jack's persistent dependence, Jack is shattered. Feeling betrayed by his only friend, he turns to a group of boys who formerly mocked him. Under the guidance of Teddy, a marijuana dealer, Jack experiences the euphoria of being "high". Bolstered by his new outlook and new "friends," he even manages to impress Felicity, a new girl in his Spanish class. He is "Superman," "Super Jack," "Stoned Jack."

Even though his Spanish teacher spends an informal class period warning his students of the dangers of drugs, Jack continues to smoke marijuana. Felicity becomes annoyed with him. He begins to do poorly in school and to show erractic behavior at home. Mike worries about his younger brother and in an attempt to show interest in Jack, invites him to work out with him in a row boat. Because Jack is stoned, he accidentally hits Mike with an oar. Mike nearly drowns. The accident costs Mike the chance to compete in the state swimming championship.

Jack, devastated by what has almost happened, is on the verge of confessing everything to his father when Mike claims the incident was an accident and credits Jack with saving his life. In doing so, he gives the younger boy a chance to gain the confidence and self-respect he needs. Jack Melon resolutely rejects drugs and makes strides to be himself – not Stoned, not Superman.

BEFORE VIEWING

1. Define the word "drug." What are some of the legal or medically-approved uses of drugs? What is the difference between drug use, misuse and abuse?
2. Why do people misuse or abuse drugs?
3. Debate the following issue: Is drug abuse itself a problem or is it the symptom of a problem?
4. Describe the ideal relationship of two siblings.
5. Discuss friendship. On what should it be based?
6. Pass out 3 x 5 cards to each student. Explain that the cards will be placed in a hat and the writer will remain anonymous. First ask each student to write on one side of the card what their parents and teachers have told them about the use of drugs. On the other side, ask them to write three sentences that sum up what they feel about drug use. Mix up the cards and read each side. No reaction or commentary is necessary but discussion is urged. The purpose of the activity is to expose the variety of points of view.
7. LIFELINE – Fill in below a lifeline of yourself that represents some of the hopes, dreams and expectations you have. You may want to include education, work, travel, parenthood, marriage, etc., at the approximate ages that make sense to you.

   Age: 14 16 18 20 22 25 30 35 50 70
8. Have students draw a circle and then fraction it off with factors that have influenced the way they think and act relating to their feelings about smoking marijuana, presenting them in proportion to their influence. Some possible influences include: parents, teachers, religious beliefs, laws, studies or surveys, fears, peers, etc.
9. Ask students to think of something they did before they were really ready. Why did they do it? Would they repeat the action now?

AFTER VIEWING

1. Looking over all of the before-viewing activities, answer the following questions based upon the film:
   a. Is Jack Melon guilty of drug misuse or drug abuse? How about Teddy? His other "friends"?
   b. Why did Jack turn to drugs? List all of the possible reasons and discuss.
   c. Was Jack's use of drugs a problem or a symptom of a problem?
   d. Was Jack's relationship with his brother an ideal one?
   e. Were Teddy and Alan really Jack's friends?
   f. How would Jack fill out the 3 x 5 card now that he has experienced these incidents?
   g. How would Jack's lifeline be completed?
   h. What would Jack's circle look like? Has this film changed your fractions any? Would it serve as an "influential" factor in your use/disuse of drugs?
2. Put together a collage using magazine pictures, photos, drawings, etc., related to one of the themes of this film. Some possible theme ideas: "The Story of Jack Melon." "What To Do Instead Of Marijuana," "How To Win Friends," "Life As A Teen," "Coping With Reality."
3. Make a poster-size chart of the current drug laws, indicating the various offenses and penalities in your state.
4. Research recent studies of the long-term effects of marijuana usage. What conclusions can you draw? Should marijuana be legalized? Should the penalities be increased?

5. Discuss the physical, emotional and mental effects of drug use.
6. In groups, write a skit in which peer pressure plays a major role. Clearly present the conflict, pressures and alternatives, but stop the performance before the resolution of the problem. Ask your classmates to predict the ending. Finish the skit as planned and discuss the alternate solutions presented by the group.
7. Rock musician Frank Zappa said, "High school isn't a time and a place. It's a state of mind." Relate his statement to Jack Melon and to yourself. Do you agree with him?
8. Many teenagers express or feel many "fears" while growing up. Some fear being criticized; others fear that they won't measure up to other people's expectations. What are Jack's fears? What are yours? What outlets do you have for your fears?
9. Is the portrait of teens presented in this film an accurate one? Why/Why not?
10. If Mike had allowed Jack to confess at the end of the film, how would the story have been different? Re-write the ending in this new way.
11. What do Felicity and Jack have in common? Why are they attracted to each other?
12. Jack seems to have trouble making friends. What advice would you have given him had he been your brother?
13. Pretend you are Dear Abby and you have received the following letters. What advice would you give each writer?
    a. Dear Abby,
    I am a teenage girl new to my school, I have met a shy classmate who is really witty. I'd like to get to know him better, but he acts strange. I think he is on drugs but underneath that there seems to be a wonderful person. Should I confront him with my suspicions? Should I just wait until he learns his lesson? Should I tell him I'd like him if he were not smoking marijuana? Sincerely, Felicity
    b. Dear Abby,
    I'm a teacher in a high school with a growing drug problem. Should I get involved? Should I ignore it and hope it goes away? Should I threaten my students? Should I share my own experiences with marijuana with them? I need your advice!
    Sincerely, Doug David
    c. Dear Abby, I'm a shy teenager who needs to know how to meet people. Help me!
    Sincerely, Jack Melon
14. Mr. David speaks of adolescence as a time of "the most important growth experiences of your life." What does he mean? Do you agree with him?
15. Mr. David also talks about the use of pot as a "crutch." Why do we seem to need "crutches"? What is yours?
16. Related Learning Corporation of America films:

    Richie
    Timothy and the Angel
    The Boy Who Liked Deer
    A Movie Star's Daughter
    Is That What You Want For Yourself?
    Friend or Foe

17. Related fictional reading:

    Tuned Out by Maia Wojciechowska
    That Was Then, This Is Now by S.E. Hinton
    Go Ask Alice (anonymous diary account)
    First Person, Singular by Vida Demas
    Drug Doubt by Roger Conant
    A Hero Ain't Nothin' But A Sandwich by Alice Childress
    The Grass Pipe by Robert Coles
    I'll Get There; It Better Be Worth The Trip by John Donovan

About Scott Baio: His life and views

He is nineteen, rich and famous. He drives a Mercedes 450SL, lives in the hills above Hollywood and dates a Playboy pin-up. What follows logically are images of wild parties, fancy clothes, drugs, sex and booze. The truth is that for Scott Baio, star of Happy Days and Stoned, life is just the opposite. He lives contentedly at home, avoids parties and has never tried hard liquor, marijuana, or drugs of any kind. His "uniform" consists of jeans–dungarees not designer–and a gold chain with a cross on it. He admits to having smoked his first and last cigarette when he was eight and to having had an "occasional beer." Otherwise, he is unabashedly a purist.

Scott talks freely of his "all-American" image. He doesn't hesitate to speak out against the crazes that his most ardent fans revel in. He isn't ashamed to admit that he is afraid to smoke dope, that he still gets punished, that he listens to his parents' advice, and that he loves school, his family and raising pigeons. He doesn't feel compelled, even to work on an image. As he states, "If you work out an image, it comes off as phoney. Basically, I'm a normal person who just happens to have a job on television. I'm myself all the time except when I'm acting."

Skeptics scoff at the kind of wholesome talk that comes out of this teenage idol, and Scott recognizes the tendency for people to disbelieve him. "Honestly, I'm not just saying these things and I'm not lying." He is refreshingly believable. His opinions flow easily and he speaks confidently about a variety of subjects despite his protestations of shyness.

Like many actors, the shyness disappears as soon as the director calls for action. A veteran performer, Scott's career already dates back ten years. He began acting "just because I wanted to see myself on television" but hated being carted around by his mother to interviews and auditions. These interviews led to work in commercials and then to his television debut in a special entitled Luke Was There (an LCA production). As his father explains, "Pretty soon, he started making more money than I did." The auditions were tough on Scott and for a brief time, he quit the business and just enjoyed playing baseball, football, basketball and hockey. His passion is athletics and he attributes his interest in sports to one reason for his disinterest in drugs and liquor. "I never had any reason to do that. I used to play ball all day long, every day. I never wanted to smoke or drink." He is still strongly against the legalization of marijuana or the lowering of the drinking age.

When he returned to his acting career, it blossomed. Feature film roles in Bugsy Malone and Foxes made him a box office attraction. Television specials such as the Boy Who Drank Too Much and Stoned feature him in the title roles. He became a regular on Happy Days and a guest on talk and game shows. Last year, he was ABC's hero on the Battle of the Network Stars.

As his success grew, so did family problems directly related to Scott's stardom. Living in Brooklyn did not make acting in Hollywood a simple task. The time came for a decision. Mr. Baio described the family meetings like this: "We had meetings at the dinner table. All in favor of moving were to put their hands up; all opposed, down. One day, there were five hands up and we did it. We sold everything and moved, and at quite an expense."

About Scott Baio: His life and views (Continued)

The expense was both financial and emotional. Scott's older sister stayed in Los Angeles for six days and decided she hated it. On the seventh day, she packed her bags and moved. Scott remembers the tears and the frustrating times that followed. "She would come out and visit for a week or two and then go back to New York. Then, her stays would extend to a month. Finally, she decided to stay here." He is delighted that she did. "When we were young, there wasn't a day that we didn't fight. Now, we are very close."

This closeness pervades the Baio residence. Scott says he and his brother are more like friends than they are like brothers. He happily allows his parents to decide on all projects and all financial affairs. In his father's presence, he eagerly states, "I could live at home forever." When his father leaves the room, he is even more adamant. "I enjoy living at home. It would be very difficult for me to move out and live alone, and I'm very frightened of marriage. I truly enjoy being around my family. They are very supportive."

The kind of support might seem strange to kids Scott's own age. For one, his father believes in ruling the house with "an iron fist." Because the "fist" is coupled with love and warmth, Mr. Baio feels that Scott understands it. Scott's reply verifies his father's assumption. "It's good to have a strong father. Otherwise, you could go astray. That's how many kids get into trouble. You see, I'm afraid of what my father would do if I ever got caught doing anything wrong."

Scott hesitates to merely sit back and rely on what he has now. He plans for his future. He wants to finish college and possibly major in animal husbandry. He likes school and reflects, "If I could do it over again, I'd like to be in seventh or eighth grade again and really do it." He would like to do more theater, something he has shied away from because, "I tried it once a long time ago and just didn't enjoy it. Now that I am serious about being an actor, I'd love to try it again." He wants to concentrate on making more feature films, but if the acting career were to end suddenly, he would love to direct or produce. If show business were to turn its back on him, he would become a veterinarian.

Despite the fact that the Baio home is in Studio City outside of Hollywood, Scott's closest friends are not celebrities. "I'm very friendly with people in show business, but my best friends are the people I met when I first came out here. They are friends who would do anything for me. I stay with this small group because I enjoy myself with them, and I don't want to go outside of that group because I don't want to be hurt."

As wonderfully naive as Scott appears, he knows what the pressures of stardom can do to a person. He knows about getting hurt and being exploited. In reflecting on Freddie Prinze's life, he talks of Prinze being a victim of everyone wanting something from him.

Scott also knows the power of television and of film to impress people. He proudly shares the story of the effect of an episode of Happy Days ("Fonzie Gets A Library Card") being responsible for a 500% increase in library cards issued in this country. Of his latest film, Stoned, he thinks, "Every school should get the entire student body to watch it. In every classroom there is a kid like Jack Melon (the main character he portrays) and I know that a lot of kids smoke marijuana. This would show them what smoking dope could lead to." He adds, "The film is very realistic. The final message of hurt is a strong one. If scare tactics work on just one person, they are worth it." Scott is not scared that playing the role of a doper or of a drunk will hurt his reputation. "People know the real me and they know that I'm simply playing a character."

The "real" Scott Baio is a kid who is together and content, modest and sensitive. He is a young man on the brink of superstardom (he blushes at the suggestion) who is grateful to family, friends, teachers, colleagues and fans for allowing him "to feel wonderful" and "to get high," not on drugs, not on booze, but on a circus act, a car, a pigeon, a baseball game, a palm tree, or a torn-down fence in Brooklyn.

TRENDS IN DRUG USE*

* Between six and seven in every ten seniors (65%) report illicit drug use at some time in their lives. However, a substantial proportion of them have used only marijuana (28% of the sample or 43% of all illicit users).
* Over one-third of the seniors (37%) report using an illicit drug other than marijuana at some time.
* Marijuana is by far the most widely used illicit drug with 60% reporting some use in their lifetime, 51% reporting some use in the past year, and 37% use in the past month.
* About one in every six or seven students has used cocaine (15%), and a similar proportion used sedatives (15%). Opiates other than herion have been used by one in ten (10%).
* Use of either of the two major licit drugs, alcohol and cigarettes, remains more widespread than use of any of the illicit drugs. Nearly all students have tried alcohol (93%) and the great majority (72%) have used it in the past month.
* Some 74% report having tried cigarettes at some time, and 34% smoked at least some in the past month.
* Overall illicit drug use is highest in the largest metropolitan areas (61% annual prevalence), slightly lower in the other metropolitan areas (55%) and lowest in the nonmetropolitan areas (48%).
* Initial contact with most illicit drugs occurs during the final three years of high school. Each illegal drug, except marijuana had been used by fewer than 7% of the class of 1979 by the time they entered tenth grade.
* However, for marijuana, alcohol and cigarettes, much of the initial use took place before high school.
* A substantial majority of high school seniors perceive regular use of any of the illicit drugs other than marijuana, as entailing "great risk" of harm for the user. Some 88% of the sample feel this way about heroin – the highest proportion for any of these drugs. The proportions attributing great risk to amphetamines, barbiturates, and cocaine are all around 70%, while 52% associate great risk using LSD.
* In contrast to the above figures, regular use of marijuana is judged to involve great risk by only 42% of the sample.
* The majority (62%) favor legally prohibiting marijuana use in public places despite the fact that the majority have used marijuana themselves.
* In addition, the great majority believe that the use in public of illicit drugs other than marijuana should be prohibited by law (e.g., 77% in the case of amphetamines and barbiturates, 84% for heroin).
* For all drugs, substantially fewer students believe that use in private setting should be illegal.
* Nearly a third of the 1979 seniors believe marijuana use should be entirely legal (32%). Nearly another third (30%) feel it should be treated as a minor violation–like a parking ticket–but not as a crime.
* Fully 32% of all seniors say that most or all of their friends get drunk at least once a week!
* Marijuana appears to be almost universally available to high school seniors; 90% report that they think it would be "very easy" to "fairly easy" for them to get–30% more than the number who report ever having used it.
* After marijuana, the students indicate that the psychotherapeutic drugs are the most available to them: tranquilizers are seen as available by 61%, amphetamines by 60%, and barbiturates by 50%.

TRENDS IN DRUG USE* (Continued)

* Nearly half of the seniors (46%) now see cocaine as available to them.
* Hallucinogens and opiates other than heroin are reported as available by only about three out of every ten seniors (35% and 29%, respectively).
* Heroin is seen by the fewest seniors (19%) as fairly easy to get.

* Facts quoted from the 1979 Highlights, Drugs and the Nation's High School Students; Five Year National Trends, published by the National Institute on Drug Abuse.

INFORMATION SOURCES

National Federation of Parents for Drug-Free Youth
P.O. Box 15035
Atlanta, GA 30333
(This non-profit organization—the only national parents group—has chapters in all parts of the country. Their publication is entitled Families In Action).

The National Clearinghouse for Drug Abuse Information
(division of the Department of Health and Human Services)
Room 10A53
Park Lawn Building
5600 Fishers Lane
Rockville, MD 20857

SELF-ESTEEM EVALUATION

Score as follows:
3 - True
2 - Largely true
1 - Somewhat true
0 - Not true

POINTS	STATEMENT OF PRESENT CONDITION OF ACTION
_____	1. I usually do my own thinking and make my own decisions.
_____	2. I often justify or rationalize my mistakes and defeats.
_____	3. I rarely experience envy, jealousy, or suspicion.
_____	4. Losing usually causes me to feel "less than."
_____	5. I normally let others be "wrong" without attempting to correct them.
_____	6. I am very concerned about what others think of me.
_____	7. I am free of guilt, shame and remorse.
_____	8. I feel vulnerable to others' opinions, attitudes and comments.
_____	9. I am prejudiced toward religious, racial or ethnic groups.
_____	10. I tend to look down on my own achievements and talents.
_____	11. I willingly accept the consequences of my actions.
_____	12. I often exaggerate and lie to maintain a desired image.
_____	13. I normally feel warm and friendly toward all people.
_____	14. I usually feel inadequate to handle a new or changing situation.
_____	15. I freely express love, hostility, joy and anger.
_____	16. I am very often belittling or critical of others.
_____	17. I am normally poised and comfortable with new people.
_____	18. I try hard to please people.
_____	19. I speak up for my own opinions and convictions.
_____	20. I have a strong need for recognition and approval.
_____	21. I normally anticipate new endeavors with a positive expectancy and confidence.
_____	22. I often brag about myself and my achievements.
_____	23. I accept my own authority and do what I think is right.
_____	24. I am often embarrassed by the actions of my family or associates.
_____	25. I accept compliments and gifts without embarrassment.

YOU ARE COPING IF:

* You feel right about yourself. You can be alone and accept your limitations;
* You are in touch with and know and understand your feelings;
* You like what you are doing, your vocation and your avocations;
* You can get interested in your environment - people, events and nature;
* You can love and accept love. You can respond to other people; and when you need it,
* You can ask for the help of others.

GUIDELINES TO HELP OTHERS:

* Help the person confront the crisis.
  (Let him/her talk about the dangers, pain, fear, etc. in "Manageable Doses".)
* Help the person find the facts.
  (The unknown is frightening because it has no limits. The facts of a situation can be handled if they are known and understood.)
* Don't give false reassurance.
  (Again, the facts of the situation are needed. False reassurance does not allow anyone to deal responsibly or intelligently with reality.)
* Don't encourage the person to blame others.
  (This is just another way to avoid facing the reality of the situation.)
* Encourage her or him to accept help.
  (Remember, it is mentally healthy to use outside resources and will strengthen a troubled individual's own position.)

FAS Information for Young Women (and Young Men)

What is FAS?

FAS is a special set of problems that babies may have if their mothers drink too much during pregnancy. Some babies may have more problems than others:

1. Heads and faces that have not formed just right.
2. Bodies that are smaller and shorter than other children of the same age.
3. Trouble in learning easy things.
4. Weak hearts.
5. Trouble bending or moving their arms and legs.

How does FAS happen?

Alcohol is a drug that gets into every part of the body—blood, bone, brain, lungs—and yes, even the baby. The more alcohol you drink, the more the baby will get, too.

One study found that more than half of the pregnant women who were heavy drinkers had babies that showed some FAS problems. Heavy drinking means a six-pack of beer per day, or a bottle of wine, or five to six 1½ oz. drinks such as scotch, vodka, or other hard liquor every day.

Drinking a great deal of alcohol all at once (binge drinking) may cause problems. There is still a chance, but a smaller one, that the baby might have problems if you drink a lot less.

Are there other causes for FAS?

Alcohol is the main cause of FAS, but we still don't know the other reasons which make FAS appear in some babies and not in others.

Sometimes, women who drink a lot also do other things that are not good for the baby or for themselves. Some smoke too much, drink too much coffee, or eat too many "junk foods" like candy, cake, or potato chips. Others don't get enough rest or exercise; some take too many other drugs.

There are many unknown reasons for birth defects. No one can be sure of having a healthy baby—but being careful of the things you eat and drink will help.

What is the best advice for pregnant women or those planning to become pregnant?

If you want to be completely safe, the best advice is to give up drinking while you are pregnant. We do not know what amount of alcohol might be bad for your baby's health.

If your friends urge you to "live it up" before the baby is born, you can tell them the facts. "You are NOT drinking for two." Your reward will be knowing that you did your best to help your baby to be born healthy.

What if I have a drinking problem and then find out I'm pregnant?

Phone your local Council on Alcoholism or a hospital for the name of a doctor who knows about alcohol and its effect on babies. Even women who were heavy drinkers and then stopped when they became pregnant have had healthy normal babies.

What does FAS stand for?

You guessed it—F is for **Fetal** which stands for the fetus (your unborn baby), A is for **Alcohol** and S stands for **Syndrome** (the signs or set of problems)—Fetal Alcohol Syndrome.

What can you do to help?

1. Follow the advice we have just given you.
2. Tell others what you have learned.

FETAL ALCOHOLISM SYNDROME

ACTIVITY

1. Show the film and allow time for class comments and questions.

2. Dicussion on questions:

   a. What drug causes the most birth defects in the unborn child? Why?

   b. What symptoms of mental retardation are exhibited in children with FAS?

   c. What congenital handicaps were noted in the film of FAS children?

   d. How can you tell by the face of the children in the film that they are FAS babies?

   e. How much is too much to drink during pregnancy?

   f. Some studies indicate that a woman should not drink during childbearing years (approx. 14-40). Why? Is this practical? What would be your suggestion for women who do drink between 14-40?

   g. Alcoholism is treatable, FAS is not very treatable after the child is born with the disease but very preventable! Do you think enough people really understand the dangers of drinking during pregnancy?

   h. If you knew someone who was pregnant and still drinking or using other drugs, what could/would you do?

   i. Other than an alcohol problem, what other poor health habits affect the unborn child?

THE RECOVERY OF CHEMICALLY DEPENDENT FAMILIES

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Description of the Chemically Dependent Family

Chemically dependent families, as do all families, seem to generate a particular system – what we might call a family life style – that is the unique product of that family's strengths, weaknesses, and general characteristics. Understanding a family system helps explain the action and behavior of the family as a whole, as well as that of each of its members. This is especially true of families who have experienced chemical problems. In chemically dependent families recurring patterns emerge and seem to have general applicability. Families with chemical problems share similar dynamics, rules and behavior that characterize and shape their systems. Insight into these three areas should help to explain many of the difficulties a chemically dependent family faces in the recovery process when the family is reaching for a new system, a new life style. Let's look at some of these dynamics, rules and behavior.

Dynamics

First are the dynamics (i.e. forces) that give shape to the chemically dependent family's rules and behavior. Perhaps the most significant dynamic deals with the family's inability to get "separateness" from the chemical problem. Specifically, the entire family in its responses toward itself and the outside world revolves around the chemically addicted person whose life in turn revolves around chemicals! Most everything the family does is in response to the chemically dependent person's behavior. On one hand, the addicted person cannot manage his own life, and yet on the other hand, his problem has such a great effect on the family that he ends up controlling the family's life through the embarrassment, fear, frustration and unpredictability his problem creates.

From this dynamic, or force, come additional problems. Most chemically dependent families experience ongoing feelings of tension, anxiety and hopelessness:

"What's going to happen next?"
"Will she make a fool out of herself again?"
"Are Mom and Dad going to fight tonight?"
"Will the boss catch on?"

All these questions and hundreds more like them reflect the tension and anxiety a family feels about its chemical problem. Brief periods of sobriety or abstinence do little to lessen the tension. Anticipation of past behavior recurring can be as painful as experiencing the behavior. Likewise after years of repeated failure and misery, the family feels a sense of hopelessness that anything can or will be done. For the children, if they are old enough, it's hanging on until "I can leave home." For the spouse it's "I've tried everything! Nothing can be done!"

In light of these dynamics it is easy to see how another force weaves throughout the family fabric, namely the family's total inability to communicate in healthy ways. As the chemical problem progresses and the family's feelings of tension and hopelessness rise, along with its inability to get "separateness" from the problem, communication among the family members becomes rigid, strained and distorted. Most direct and honest communication has been driven underground in frustration. These various dynamics in turn establish a set of rules which a

chemically dependent family lives by. For most suffering families a great deal of time passes before these rules are challenged or broken.

Rules

The unique thing about family rules, especially in chemically dependent families, is that the rules are stated directly. Implicit within the family is a set of rigid, harmful rules that govern the actions of the family, and that the family unknowingly accepts. One rule that seems to apply universally is that everyone in the family is required to be an enabler. Much has been said about how the non-chemically dependent spouse is an enabler, but the children in such a family are also required to obey this rule. Failure to do so can bring wrath and abuse and accusations of disloyalty and ingratitude!

Another common rule says that family members will not talk directly or realistically among themselves or with others about what's really going on in the family. Everyone knows about the chemical problem and reacts emotionally to it, but few such families engage in direct, honest communication about it. To break this no-talk rule causes a negative reaction that most family members are either too sick or fearful to risk. There is also the rule that implies that someone or something is responsible for the chemical addiction, other than the chemically addicted person himself. Scapegoats such as bosses, shrewish wives, economic hardships and irresponsible children are sought and easily found. All members of the chemically dependent family play by this rule. What we have here is massive "sincere delusion" on the family-wide basis. In summary, these various rules produce a rigid family system where members are unable to solve their problems, and where they knowingly perpetuate the chemical problem. This can be seen in the behavior these rules produce.

Behavior

If one rule demands that all members of the family be enablers, it follows that the family will display a wide range of enabling behavior. Wives calling the boss to report that the flu bug has hit the family again, children explaining to the bridge foursome that mother forgot about the card date and is visiting someone else, or the husband once again carrying his passed-out wife upstairs and carefully putting her to bed. These examples typify the kinds of enabling behavior chemically dependent families show. In addition, as the disease progresses the family collectively and singly engages in more and more isolating behavior. Withdrawal from each other and avoiding contact by staying away from home or in one's room is frequently seen. Contact with friends and social acquaintances either stops or is significantly reduced. This pattern of the family withdrawing from itself and from society is especially evident in the later stages of the disease. This isolationist behavior makes help for a sick family even more difficult to obtain.

Imbalance and distortion of family roles constitute another set of behavioral responses to the family sickness. Older daughters often totally assume a mother role to keep the family going. Wives, in response to their sick husbands, become financial managers, decision makers, disciplinarians and job seekers. In other words, conventionally held roles or shared role responsibilities are parcelled out in a way to maintain family survival, not family health!

In addition to this behavior is a whole series of inconsistent and irrational actions by all members of the family in response to the frustrations and hopelessness the family feels about its situation. Each member of the family has his or her own way of reacting to the chemical dependency. For example, on one day the non-chemically addicted spouse might respond with the "silent treatment" as a way of showing frustration and anger. However, on another occasion that same person is seen emptying out half-filled bottles and having a full-blown rage. Children, too, manifest inconsistent and irrational reactions toward the problem. Angry threats

of running away and tearful pleading to change behavior will often come from the same son or daughter in a short span of time. Again, we have a sick family coping with a chronic, progressive disease in unhealthy and confusing ways. What we now have is a family whose dynamics, rules and behavior are so shaped by chemical addiction that the family operates under a rigid, sick system that needs "family recovery" to break that system and begin positive growth together.

The Recovering Family

What happens within the family system described above when a chemically dependent person, after going through treatment, returns home and re-enters the family? What are the problems which arise and what can families do to counter the deterioration of their family unit? These are some of the questions that will be discussed in the next section.

The expectations of the recovering patient and other family members play a major role in the problems encountered by the recovering family. In fact, these expectations probably direct the behavior and attitudes of all family members during the post-treatment period. There are many different expectations, for example:

"Will she stay sober?"
"How angry is he with me?"
"What's Dad like when he's sober, anyway?"
"Whew, our problems are over, Dad's finally sober."

Generally, however, these expectations fall into two areas: Those concerning the roles that family members expect to assume or continue: and those concerning the new family environment and what it will be like. Let's look separately at each of these areas.

Roles

During the time when the patient is actively involved with chemicals, he eventually abdicates his role. This drastically affects the family structure, and usually by the time the patient has gone through treatment, the family has reorganized around the new framework which no longer includes the patient in a functioning role. This is obvious in the case where the patient has left the family or lost his job. But even in the case where the patient holds a job and still is present in the home, other family members are the ones actually running the show – taking care of the bills, taxes and other business matters, or attempting in other ways to keep the family together. So when the patient comes home after treatment or after achieving sobriety, there is often conscious, as well as unconscious, resistence to accepting him as a responsible family member and turning his role back to him, whether it be a decision maker, financial manager, or someone from whom other family members will seek counsel or emotional support. A daughter who has had to assume full responsibilities of the mother, or a son who has had to assume the father's role, is often very reluctant to give up these responsibilities just because mom or dad is back home.

The patient, too, has his own set of expectations involving his role:

"Will I be able to fulfill my role in the family as I feel it should be?"
"Will they accept me?"
"I wouldn't blame them if they didn't want me back!"
"Do the kids hate me?"
"Will I be able to deal with all our problems and stay sober?"

Or the patient may fully expect that the family is waiting appreciatively with open arms to welcome him back into his former role as "loving" father and husband, and that his children

will "shape up," be responsible and be open to communication with him – ready and willing to help things run as smoothly as possible. What the patient does not realize is that the family has not been through treatment (at least not as intensive as his and certainly not with corresponding impact) and that they are probably a long way from accepting him back into their midst with open arms. Even if they wanted to do this, they could not, because there are just too many past experiences in the way. These are the feelings that the family must work together to identify, share and work out if they are going to develop a successful relationship together. There are a great many hostile feelings relating to the chemical experience sometimes on the surface and sometimes hidden very deep. Many of these hostile feelings relate directly to the role changes and expectations of both patient and family member. These role expectations then will have a direct effect on the relationship that will be developed within the recovering family environment.

New Family Environment

The second area involves the family members' expectations about the new family environment. They expect the patient to be "fixed" after treatment – that he will be as they remember him before he started actively using chemicals. They also expect that the family itself will be different – maybe happier and more relaxed, functioning efficiently and smoothly. So when these expectations are not met and in fact we find that the opposite is true, then disillusionment, hostility, anger and sadness result.

The fact is that in most post-treatment families, problems merely become more evident. The problems of trying to re-establish roles occur and the patient may be in a highly nervous and impatient state – often loaded down with feelings of guilt and remorse. There may be new financial problems that the patient is trying to deal with. Children may be showing many signs of disturbance in school or within the home. The problems are still all there. The only difference is that the patient is not actively using chemicals on a day-by-day basis – at least the family hopes not. There is still fear among family members that the patient will slip back into using chemicals. This fear is one reason why family members tend to "take care of" the patient after treatment. This usually results in a "honeymoon" period with the family during the immediate post-treatment weeks. Here the family is trying extra hard to keep the peace and avoid conflict. They are afraid that the patient will go back to the old ways and that once again the family will plunge into chaos. This "honeymoon" period may last for two weeks or as long as a year, and by this time the suppressed hostilities of all family members will begin erupting – the kids acting very hostile, arguing and fighting with both parents, spouses fighting openly and covertly with each other and the children.

Another thing that probably motivates this "honeymoon" period behavior is the family's feelings of tremendous relief at having the conflicts and hassles of active chemical addiction over. The family in a sense is floating on its good feelings and expectations about how things will be from now on. Initially, this may be a necessary part of the re-entry and readjustment period, but the "honeymoon" should end quickly or it will just intensify the pressure and building up all of the latent hostility and negative feelings that family members have felt throughout the active addiction period.

We can see that communication within the recovering family is crucial, and herein lies another problem concerning family expectations. As a part of the new environment, family members tend to feel that their contact and communication with one another will improve. This is extremely difficult since they have no model. They dont't know how to communicate openly and honestly with each other. They don't know what a good communication system in a family looks like. In the past, the pattern has been just the opposite of this. People have repressed feelings and emotions and they have not communicated their fears and frustations about the chemically dependent parent and the effects this has had on the family. They are

really caught in a trap. They must communicate to get well and begin positive growth and recovery as a family and individually; yet, they don't know how to begin. In addition, most of the post-recovery problems will force them to continue in their non-communicating roles (problems such as taking care of the patient, sitting on their feelings, not expressing their anger, resentment, fear, hostility or sadness).

But the pattern must change in order for the family to continue to recover in all areas – not just to keep the patient from using chemicals, but to learn to communicate and get back in touch with their own feelings (and deal with their sadness, as well as their anger and frustration). There must be recovery for all members. At some point the whole family must get together and begin working on their problems.

We see a real need for all chemically dependent families to have follow-up work together in order to break the rigid, sick family system described earlier in Part I. It's not enough for mom and dad to go to AA meetings or for the children to attend Alateen groups. There must be time when the whole family is working together for recovery. This can be accomplished best by seeking help from outside organizations such as family counseling groups, courses in family communications, post-treatment family counseling.

Summary

Many of the problems of the recovering family are caused by the expectations of all family members. Generally people assume that after sobriety is attained, the family will begin to function smoothly and efficiently, and that things will return to the happier days of the past. Each family member harbors a lot of resentments, anger and sadness which have built up during the period of active chemical use, and this must be dealt with as a family. The real problem here is that the family really doesn't know what good communication is or how to learn it and put it into practice. We are suggesting therefore, that as soon after treatment as possible, the whole family get together in a counseling setting to begin learning how to get back in touch with themselves and each other. Remember this, a major characteristic of the chemically dependent family is that members do not share their real feelings openly with each other. The walls to communication have been built high and wide, and family recovery is the process of learning to break down these walls.

CHILDREN HELD PRINCIPALS IN "A HIDDEN TRAGEDY"

By William G. A. Boama, M.D.
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The following article, "The Children of Alcoholics – A Hidden Tragedy," was presented by the author at the second annual meeting of the American Medical Society on Alcoholism in Baltimore.

The children of alcoholics are the principals in a hidden tragedy. Often they remain pathetically invisible to the professional treating the alcoholic.

Worse still, the family tends to be totally ignored in the recent emphasis on rehabilitation of alcoholics; all the efforts and virtually all the literature is aimed specifically at the alcoholic and his alcoholism.

BEHAVIOR SIMILARITIES

And yet, we know now that over half of all alcoholics have an alcoholic parent. Furthermore, there seems to be a high incidence of drug abuse and mental disturbance among the children. What recognizable problems can we find in the child's early life that can explain this phenomenon?

In treatment, the alcoholic's children are seen to have significantly similar behavior and thought patterns. In the home, these children feel unloved and neglected and as one child said, "My parents make you feel like a burden. They would be better off without you".

It is perfectly understandable that the alcoholic in his uncomfortable and guilt-ridden, anesthetized state is unable to establish a loving and meaningful relationship with his child. The alcoholic sees the world through a fog that is impenetrable to the emotions of the people surrounding him or trying to reach out to him. Likewise, in this state, he isolates himself and makes it impossible for him to reach out or relate to others, even his children. He is self-centered and preoccupied with himself.

OTHER PARENT ANGRY

The children cannot turn for attention and love to the spouse, either, since the other parent is often too overcome with anger, frustration, and futility to be of any comfort. This parent most often has her own share of inner conflicts. Her inability to recognize the superficial relationship with her spouse, her neurotic compulsion to take care of "mother" the alcoholic, leaves little time for the child.

More often than not, she is even unable to provide the child with a caring atmosphere since it is no accident that she has picked an alcoholic spouse. (If it is the mother who is the alcoholic, the situation is even more desperate. Children, especially young children, are more dependent on their mother. Obviously, alcoholic mothers cannot care for either their children's physical or emotional needs.)

DISTRUST, REJECTION

The alcoholic's children react to this situation with intense feelings of distrust, rejection, worthlessness, and repressed rage. The inconsistent, erratic behavior of the alcoholic and the spouse make the child feel insecure.

Thus, the home life provides none of the usual sense of security, no haven to the child from the frustrations of the outside world. In fact, the child is in constant fear of physical violence, due to the aggressive behavior of the alcoholic.

WITNESS TO VIOLENCE

He also is a witness to the constant violence between his parents and fears the threats of parently separation he so often hears. This separation may occur from time to time and this increases the child's apprehension and insecurity. "Who will be there when I get home from school? How will they act when I get there?" The situation at home is further aggravated because the child emulates the parent in taking out his pent-up frustrations violently on his siblings.

It is obviously difficult for a child to identify in a positive way with an alcoholic parent. Consciously, the child rejects the ugly identification, but unconsciously he incorporates the imperfect parent. This creates a confusion in the child's behavior because of the conflict between his conscious insight and unconscious image.

The confusion is manifest in the child's behavior in school and other areas of socialization. School mental health workers frequently find a startling correlation between a child's adjustment problems and his parent's alcoholism. The alcoholic's child is unable to concentrate in school due to his anxieties about his home life. He brings many of his aggressions to school with him and is likely to antagonize his teachers and his classmates by his anti-social behavior.

The dulled state of the alcoholic, his erratic, violent behavior isolates him from society and his family – he is unable to relate to or even tolerate other people; rather, he is lost in his own personal world. The isolated behavior of the parent sets a pattern for the child. This is reinforced by the child's shame at his parent's home behavior.

Obviously, the child does not want outsiders to know about his home situation. He presents a false front to his peers, lying or fantacizing about his parents.

This obviously would prevent his forming close friendships. Since such friendships are necessary youthful experiences, the child is already caught up in the vicious circle that will lead to alcohol, drug abuse, or other maladjustments.

BEHAVIOR PROBLEMS

A recent study indicated that male children of alcoholics were assertive, rebellious, overtly hostile with an over-emphasis on masculinity. The girls, on the other hand, tended to be self-defeating, vulnerable, pessimistic, withdrawn, and fluctuating in their moods.

In short, these children have behavior problems. (Although these children are obviously

disturbed throughout their development, they are most symptomatic in early adolescence.) They do not do well in school since they find it hard to concentrate. They complain life is no fun. They are often forced to take over the demanding role of a parent – cook the meals, clean the house, put the younger children to bed – since a parent is often either missing or emotionally and physically incapacitated. School is no better.

Whenever the child is out of the house, he is constantly anxious about how things will be when he returns. He cannot rely on the parents at home and he isolates himself at school because he is ashamed to tell anyone about his anxieties. He fears a humiliating pity from those who might find out. Except for the concern of an occasional individual, doctor, teacher, or minister who looks below the surface behavior, this child can expect little attention or comfort from society.

If the alcoholic parent stops drinking, the situation does not seem to improve much. Short-term sobriety generally makes matters worse. The disillusionment of the child when the parent resumes drinking is shattering. All the hopes and dreams of having a so-called "normal" parent are once again crushed.

CAUGHT IN THE MIDDLE

If the alcoholic stays sober, a normal family life does not automatically follow. The individual is often too preoccupied with his recovery to even think about re-establishing a relationship with his wife and children. The strained feeling between the spouses often remains. Often the non-drinking spouse feels threatened and insecure at suddenly being confronted with a different more assertive person. This, together with her understandable anger, may goad him to flee the home. The child is caught in the middle.

Many treatment modalities encourage the alcoholic to attend meetings so that he is at any rate spending as much time away from home as he formerly spent drinking. All his social relations have to be relearned. This causes a further strain on spouse and children, who have already suffered much.

It is clear that the pathology of the alcoholic's family requires as much attention as the alcoholic himself. This is true for two reasons. One is quite simply that the families and the children, especially, suffer untold anguish, leaving them scarred for the rest of their lives. Secondly, if we are ever going to make a dent in the enormous numbers of alcoholics by practicing preventive medicine, it seems obvious to start with the children of alcoholics, who, as I mentioned, constitute 52 per cent of all alcoholics.

We certainly should not neglect the anguishing mental problems of the children. It is obvious that the helping profession cannot be satisfied when the alcoholic is diagnosed and treated or sent to A.A. or a specialized clinic.

The family has to be involved, all effort should be extended to make it an adequate unit again, through family and other therapy. (A small number of spouses and children are able to receive help through Al-Anon and Al-Ateen.) Often if the family will not cooperate, treatment should be available to the children. Perhaps the law should even provide that children can be treated against parents' wishes, if necessary.

Then the specialized treatment facilities. It is pathetic that in a comprehensive alcoholism

program like we have developed in University Hospital, not one clinic, group, or treatment modality concerns itself especially with the treatment of the children of the alcoholic. It is my feeling that we labor under the heritage of not only focusing primarily on the alcoholic, but feel that paying attention to the suffering children might do harm to the alcoholic through his possibly increased feelings of guilt and shame.

CHANGE OF ATTITUDE

For the existing alcoholic treatment centers to incorporate the family and especially the children into the rehabilitation process, will require a change of attitude and approach.

Above all, it would require expanded treatment facilities and extra personnel. This, of course, is a sine qua non in any preventive medicine program.

The question is always, do we continue to treat diseases such as alcoholism without making an effort also to treat the anguish of the families and at the same time, prevent future alcoholics or mentally ill adults. Are we willing to pay the price now for a future benefit? Our society does not do this very readily.

THE EFFECT OF PARENTAL ALCOHOLISM ON ADOLESCENTS

by
Herman E. Krimmel* and Helen R. Spears**

On a mild summer evening, a Mr. Shaw took his son, George Bernard, for a walk along Dublin's Grant Canal. The elder Shaw, feeling jocular from the effects of good whiskey, threatened to throw his son into the water and, in a clumsy pretense, very nearly did. The boy had never really been aware of his father's tippling habits, but this incident opened his eyes. "Mama, he cried on his return, "I think Papa is drunk!" Bitterly, Mrs. Shaw replied: "When is he anything else?"

In recounting this episode, one of Shaw's biographers, St. John Ervine, observed that "the disillusionment of a child is a bitter experience and is never forgotten." Years later when sentimentalists accused Shaw of disrespect for his father's memory, the playwright angrily recalled the anguish that had been created in the home and how, as Ervine says, Mr. Shaw's chronic intoxication made Dublin a desert for the family.

There was violence in the Shaw home. Although the father was an amiable enough man when sober, his temper was fearsome when drunk. The slightest offense was enough to make him smash anything breakable that might be lying about. Frequently, the three children "huddled apprehensively in the kitchen, hoping that their father would be sober when he came home from his mill."

His behavior cut the family off from the social life of the numerous Shaw clan, and they suffered the stigma of being outcasts. Because he was unwelcome, his wife and children felt excluded too. This pattern is familiar in the families of alcoholics. It has been repeated countless thousands of times.

George Bernard Shaw was, perhaps, a genius. At the very least he became one of the giants of dramatic literature. Nevertheless, the memory of his father's alcoholism was long and deep. It left scars and made him a fanatical teetotaller. This dedicated abstinence may not have been an ideal defense, but it served Shaw well enough and was socially innocuous. But if fanaticism, even in an isolated area, can be the result in a George Bernard Shaw, what happens to a lesser person?

It has been generally agreed that parental alcoholism is detrimental to children. There have been few studies in this field, but in those that have been made, the results have been similar. Leontine Young recently reported in a study of abused and neglected children that alcoholism was one of the most acute problems. In 300 families, 186 parents were severe and chronic drinkers and their drinking constituted a primary family problem.

In 1927, Channing found that in 2,155 families of delinquent children, 850 fathers and 153 mothers were alcoholics. (3) More recent investigations by Nylander of Sweden and Holden and McKay in this country revealed a significantly high incidence of anxiety neurosis, depression, hostility and sexual confusion among the children of alcoholics. (4,5,6,)

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In an unpublished report, G. P. Johnston studied evaluations by mothers of their children's problems. These mothers included wives of active alcoholics, recovered alcoholics and non-alcoholics. More of the children of alcoholics were seen by mothers as having problems and the mothers perceived more problems per child. Children of recovered alcoholics were seen as having fewer problems per child. Children of recovered alcoholics were seen as having fewer problems as a group and as individuals but were still significantly different from the children of non-alcoholics. (7)

The sample in our study included 125 adolescents of both sexes, about evenly divided. They ranged in age from 13 to 21, and the average age was seventeen. They included children of our clinic patients, members of Alateen groups, those on probation in juvenile court, clients of private agencies and delinquent children in state institutions. The control group of children of non-alcoholic parents numbered only 35 and, unfortunately, they were almost all from state institutions. However, they did provide the basis for some comparisons.

In a number of areas there seemed to be no significant differences among alcoholic and non-alcoholic families. Disciplinary measures such as curfews were similar as was the latitude permitted to children in selecting friends. The demands on the children to earn money and possibly restrictions on their use of it could not be clearly differentiated by groups. In these areas there were differences but they were on an individual basis, as they might be in any other segment of society.

However, there were areas in which the impact of parental alcoholism seemed clear. Certain difficulties appeared almost universally in alcoholic families and were relatively uncommon in non-alcoholic families. There were structural changes that left children confused and without identification. There was widespread violence. The ability of the children to form healthy relationships were severely crippled. Goals were abandoned and there was a retreat to defenses that were sometimes as workable as they were unhealthy.

One factor should be emphasized, however. The impact of alcoholism affected all groups without regard to the social, cultural, racial or economic situations.

The change in family structure occurred almost without exception in the alcoholic families, and the adolescents were resentful of the sense they had of being "different". They didn't always say it that directly, but they were obviously uneasy in the knowledge that their parents were not like other parents, their families were not like other families.

In our society it is customary to regard the father as head of the household and for better or worse, children want it that way. However, few of those in our sample saw their fathers in that role. A typical remark was that of a 17 year-old boy who said that his father was either away from home working or drinking or at home sleeping off a hangover.

It is difficult, frequently impossible, for the child of an alcoholic to establish the necessary identification with an alcoholic parent when the latter no longer behaves as a parent and is relegated to the position of another child. This has been verified in many interviews with adolescents and confirmed by wives who say they do not have husbands but only additional children to care for. Among adolescents who need identification, this can be a source of severe conflicts.

If a parent were just relegated to an inappropriate position, the situation would be bad enough, but the fact remains that he cannot be ignored. He may use his drinking to insure his position

at the center of attention. The focus frequently remains on the drinking of the alcoholic member because family plans, even family economics, may depend on his intoxication or sobriety. Long range planning is almost impossible because of his unpredictability.

Deterioration within the family is accompanied by guilt which may spread like a virus to spouses and children. They are compelled to witness or participate in situations that make them feel, however unjustly, guilt by association. With guilt comes isolation. One mother withdrew from all outside groups because she was apprehensive about her husband's treatment of the children while she was absent. She stopped going to a monthly bridge club and withdrew from the church choir after she returned from one rehearsal and found her alcoholic husband in bed with their 13 year-old daughter. Somehow, she blamed herself as well as her husband.

Decades have passed since the Shaw family was forced into isolation but intolerant community attitudes continue to force family withdrawal. Our experience supports Jaan Jackson's statement that ". . . alcoholism in the family poses a situation defined by the culture as shameful but for the handling of which there are no prescriptions which are effective or which permit direct action not in conflict with other cultural prescriptions . . . the cultural view is that alcoholism is shameful and should not occur . . ." (8)

An adolescent who repeatedly had to haul his father from the tavern, take him home and put him to bed told of the anger and nausea that nearly overwhelmed him each time it happened. He was afraid to face his friends after each episode and equally afraid to abandon his father.

It is scant comfort for a child to be told that the professional party line is that alcoholism is an illness rather than a sin or evidence of moral turpitude. He is far more sensitive to the whips and scorns of classmates and neighbors than to the reassurances of social workers and pyschiatrists.

Isolation and loss of external contacts compel increasing concentration on the behavior of other members of the family. This can only emphasize changes in family structure. Moreover, in many cases, it exposes the child to exploitation by both parents. Most of the children in the study were used as weapons in the war between alcoholic and non-alcoholic parents although they were not always aware of the exploitation. Many of the adolescents felt a disturbing sense of inner conflict and knew that somehow it was related to drinking but could not identify the cause.

Sometimes parents realize what they have done and are shocked by the realization although this does not necessarily repair the damage. One mother told of enlisting the aid of her children in what she called the "ceaseless war against their father." They defended her in arguments, supported her efforts to foil her husband's insatiable thirst for whiskey and helped hunt bottles he hid in the basement.

If, in his sober periods, they expressed affection for him, she was resentful. Finally, she saw how this constant tug of war resulted in a pitiful sense of insecurity for them and made them noticeably nervous and unstable . . . What they developed, she added, was "a feeling for their father far worse than good, clean hate. They developed a patronizing pity for him that was in reality no pity at all. They regarded him rather as a combination of clown and idiot . . ."

Almost all the adolescents emphasized the demands made on them to take sides. This happens in other families, too, but where alcoholism is involved the lines are more likely to be clearly drawn between the "good" and the "bad", but this can increase rather than alleviate conflicts.

Mothers were most successful in commanding loyalty and there was almost unanimous determination among the boys to protect the mother whether she was the alcoholic or non-alcoholic. The girls were more divided although they, too, tended to protect the mother. One girl frequently feigned illness to stay home from school when she thought there might be trouble because she felt she should be where she could intercede.

It was our observation that the need felt by children to act as protectors decreased as they grew older. Their fears diminished as they became accustomed to the situation, and they seemed to adopt a studied aloofness to parental conflicts. Moreover, many could afford to resist involvement as they realized they were not responsible for parental difficulties. This had been a source of desperate anxieties for many when they were younger.

The reorganization of the family frequently compels children to prematurely assume adult responsibilities. One 15 year-old boy whose father's alcoholism erupted when the child was only nine, was told by his mother at that time that he would have to be the man of the house. That is reminiscent of the lament of the alcoholic father in Days of Wine and Roses when he cries out to his wife "We get drunk. We stay drunk. Poor little Debbie. It's like we're her children instead of the other way around . . ."

We know that adolescents sometimes succeed with these responsibilities, but that is not synonymous with suggesting that the burdens are healthy.

Regardless of the degree of the distortion of structure, violence was almost universal in families with alcoholism and infrequent in others although the latter were often riddled with different kinds of pathology. Generally, it seemed that the alcoholics drank, in part at least, to overcome a sense of inadequacy. Consequently, passive fathers exploded into uncontrollable rage under the influence of alcohol . . . many of our subjects had been witness to or victims of such outbursts since early childhoood.

Violence, of course, is not the monopoly of male parents. In one family both parents had been drinking for eight years at the time we saw the two teenage children. The mother became so violent that she stopped at nothing to harm those who were "against her". The injuries she inflicted on her husband included broken fingers, cracked ribs, teeth knocked out, a broken nose and innumerable stab wounds from knives, forks and other weapons.

Both children said the father was also a severe alcoholic although rather passive when drunk. Indeed, one of their complaints was his inability to do anything about the situation or even to resist his wife's fury.

The scars of violence can last a lifetime. Actress Ethel Waters was raised in a home that included two aunts whose drunkenness was unbearable. In her autobiography, His Eye Was On The Sparrow, Miss Waters recalls that their inebriation and the violence and quarreling it brought out was something she could never accept. On an unforgettable Christmas Eve one of the aunts came home rioutously intoxicated. Ethel vigorously objected. The aunt cursed her and threw a hatchet. The hatchet, fortunately, missed its physical target but the act itself made emotional cuts that were deep and lasting.

One factor that impressed us was the direct relationship between the impact of violence and the age at which children first witnessed these episodes. The younger they were, the more devastating and lasting the effect. After the first incident, they were always waiting for the next and the next after that. They learned to equate drinking with violence, almost as a conditioned response.

Another finding of the study was that these multiple manifestations of conflict, turmoil and distortion seriously impaired the ability of children to form healthy relationships in or out of the family.

Few of the adolescents in the sample had developed that ability and we felt that they had never really had a chance. Most alcoholic families are models only of inconsistency and instability. The periods of sobriety may offer interludes of peace and warmth and even a measure of happiness to the non-alcoholic members of the family but they are only interludes. For children there may scarcely be time to readjust their thinking before the alcoholic parent is off and running again. Most of the boys and girls expressed disappointment and resentment at being let down over and over again by the alcoholic parent.

A 17 year-old boy, seen at a private agency because of truancy and school failure, finally revealed his brooding resentment about the numerous parental separations that resulted from his father's excessive drinking. For him however, it wasn't any better when they were together because conflict erupted every time the father got drunk. When the father was not drinking he was passive, ineffectual and removed from the mainstream of the daily functioning of the family.

This boy had never known an example of mature love and the constancy of a healthy parental relationship. He never knew what to expect so he withdrew. He was afraid to test relationships because he had been bruised by adults and was uneasy with his peers. Although he was an attractive young man, he was inhibited with girls and doubted that he could ever achieve an easy, comfortable relationship with them.

Another boy became dejected and hopeless about his situation at home and while he refused to leave physically, he withdrew emotionally. The school described him as an "isolate" although quite dependable and hard working. He had no friends because he was suspicious of the motives of people and could not accept anyone who was not "perfect" in every way.

These are selected examples and we know that the same difficulties may be encountered by adolescents in non-alcoholic families. But alcoholism is a major cause of instability and it is significant that it happens to so many children with alcoholic parents.

The insecurity which is a barrier to relationships is often increased in alcoholic families by the most inevitable war between the parents which compels them to devote most of themselves to warfare instead of to total family living. There is seldom genuine peace – just truces. Children, being resilient organisms, may strive again and again for healthy relationships but just as achievement seems close, it is blocked by the appearance of an alcoholic parent on another binge.

How many times can they try, how many times can they accept frustration without giving up? The position of the child of an alcoholic marriage is like that of a ballplayer on the bench who is never called into the game and cannot, therefore, develop his skills. The ability to develop healthy relationships comes only from practice.

Children stunted in their relationships seem to be also limited in a sense of their own worth. Among the adolescents in study there were severe limitations and distortions of self-image because confidence and self-assurance find little nourishment in an atmosphere of doubts and recriminations. Many of the alcoholic parents were perfectionists – for everyone except themselves. They made impossible demands on children in behavior and accomplishments to compensate for their own failures. The children, unable to meet these demands, developed a sense of impotence and worthlessness.

For many young boys and girls in our study all these factors added up to a state of anomie. Many aspired to higher standards than that of their parents, to a life undamaged by, if not necessarily free of, alcohol. But aspirations were vague and undefined. This phenomenon may not be uncommon among adolescents but among these children everything was subordinated to the immediate goal of finding a way to live with an alcoholic parent or to escape.

Many found it difficult to plan for a career or for college because the experiences of a young lifetime conditioned them to accept defeat before they started and to believe that their plans could never find support.

An effort was also made to examine the defenses used by the adolescent children of alcoholics and they varied widely. Some tried to retaliate in a way that would hurt their parents or enable them to get even. A 14 year-old boy stole cars to embarrass his alcoholic mother. Another boy, whose father was "the meanest and biggest drunk there ever was," resorted to vandalism. A girl said bitterly: "My mother isn't fit to be a mother. That's why I ran away from home five times".

Others attempt to take refuge in impeccable behavior as if to prove their superiority to alcoholic parents. One girl enjoyed the role of counselor to her high school companions for which she regarded herself as uniquely suited because she had "seen more of life".

Some find sanctuary in laughter although it seems to be laughter without mirth. As Shaw said of his father, "The drunkenness was so humiliating that it would have been unendurable if we had not taken refuge in laughter . . ."

Many withdraw emotionally and insulate themselves against further hurts. Incidentally, the suggestion that the child should try to view the alcoholic as two people, one drunk and one sober, does not seem to work well. According to one investigator, the child is most likely to see the alcoholic as one person who is too upsetting and unpredictable to allow anything but complete rejection.

What does all this mean in terms of those who work with children of alcoholic parents? It would seem obvious that the first goal must be to eliminate the alcoholism since that is the major cause of damage. In one study of 44 children of alcoholic parents, Holden found many problems but observed that the treatment of the child in a psychiatric clinic tended to be successful if the alcoholic recovered. (9)

We say that this should be obvious but, unfortunately, it is not to many social workers and other professionals. Despite the high incidence of alcoholism in agency caseloads, it is frequently avoided because it is not the so-called presenting problem and social workers are devoted to presenting problems.

A caseworker in a youth agency, for example, worked with a disturbed adolescent who stole cars, was a chronic troublemaker in school and frequently stayed away from home for two or three days. This boy was a tormented mass of anal, oral, and genital disorders which the worker explored with dedicated dilingence. The boy also happened to have a pair of alcoholic parents who made life utterly miserable. The worker, however, paid little attention to these parents because of the presumed hopelessness of alcoholism. He did, of course, try to get the boy to understand his parents which was a bit difficult when the crockery was flying, or when the father hurled the portable television set at his wife.

For some reason, the boy never adjusted to this kind of family life and, after eight months, he

terminated his contact with the agency. The caseworker noted in the record that the client, unfortunately, did not seem ready to make effective use of casework treatment.

If the approach had been different and the alcoholism of the parents had been worked with at the outset, lengthy work with the boy might have been unnecessary. In any event, if a direct approach to the problem of the parents had been successful, the boy would have been given an opportunity to tackle his own problems in a much healthier environment.

In similar cases, countless hours are wasted in countless agencies in an effort to help spouses or children or relatives to adjust to alcoholics when it might be far more effective and probably easier to alter the alcoholic.

Admittedly, however, there are times when the alcoholic cannot be reached, and it becomes necessary to work with others in the family.

The cases in the study indicated that the degree of success with this approach especially as it applied to children is directly related to the strength of the non-alcoholic partner in the marriage. The damages were always less when this partner had not surrendered. If help must be concentrated on the non-alcoholic parent, it should be directed toward the mobilization of those constructive strengths to be employed for the greatest good of the greatest number in the family.

This does not mean helping the family to simply adjust to the alcoholic, although it may involve adjustment to his presence. On the contrary, it can mean moving away from total involvement. This does not necessarily mean forgetting abandonment of the effort to get the alcoholic to accept help because part of the work with the family may be to aid them in motivation of the alcoholic. This can involve work with both non-alcoholic spouses and children.

Some authorities have indicated that it is not possible to say with assurance that alcoholism is the factor that is primarily responsible for the difficulties we have outlined. This may be true. However, the regularity of the factors in alcoholic families must indicate that the risks are great and that even the social and psychological situation of the family is already grim, the addition of alcoholism makes it tragically dramatic.

REFERENCE NOTES

1. Ervine, St. John - Bernard Shaw, William Morrow, 1956.

2. Young, Leontine - Wednesday's Children, McGraw-Hill Co., 1964

3. Channing, A. - Alcoholism Among Parents of Juvenile Delinquents. Social Service Review, Vol. 1, pp. 357-383, 1927.

4. Nylander, I. - Children of Alcoholic Fathers, Acta. Paediat, Stockholm, Vol. 49, Suppl. 121, p. 134, 1960.

5. Holden, M. - Treatability of Children of Alcoholic Parents. Smith College Studies of Social Work, Vol. 16, pp. 44-61, 1945.

6. McKay, James R. et. al. - Juvenile Delinquency and Drinking Behavior, Journal of Health and Human Behavior, Vol. 4, pp. 276-282.

7. Johnston, G. P. Quoted by Joan K. Jackson, Ph. D. - Alcohol Education for Classroom and Community, 1963 (Raymond G. McCarthy, Ed.) p. 163.

8. Jackson, Joan K., Alcohol and the Family – The Annals, January 1958, pp. 90-98.

9. Holden, M. op. cit. pp. 44-61.

LOVE IS DESTROYED

Love cannot continue to exist in this type of action and interaction. The alcoholic uses alcohol to escape the pain by drinking and learns how to use the family to escape the pain of the consequences. The family suffers when the alcoholic drinks and then suffers the painful consequences also. If the family bears the brunt of the drinking and absorbs its consequences, then compassion cannot exist. Compassion is bearing with or suffering with a person, not suffering because of the unwillingness of the other person to suffer. If this condition is allowed to continue by the family, love is gradually destroyed and replaced by fear, resentment and hatred. The only way love can be retained is by family members learning not to suffer when drinking is in progress and refusing to undo the consequences of drinking. Anything less than this is not compassion, and any relationship without justice and compassion is not love.

Knowledge of the nature of alcoholism as an illness and the courage to live by this knowledge are essential if fear is not to replace love in marriage. Unfortunately, many families suffer repeatedly from drinking and its consequences, thinking this is required if they love the alcoholic. The tragic result is that alcoholism is thereby perpetuated, and fear and resentment take over human emotions. This is why family members, especially the next of kin of the alcoholic need help if the disease is to be arrested and recovery initiated. Otherwise, the entire family becomes ill emotionally. This condition is but another symptom of the progress of the disease.

Before leaving this area of discussion, it is necessary to state that there are wives who need alcoholic husbands or husbands who need alcoholic wives to gratify their own neurosis. This may be true of parents or brother and sister as well. The family must always take a close look to be certain this need does not exist. Masochism is the need to suffer in order to find a sense of worth or value in life. It is all too often seen in wives and mothers of alcoholics who use an alcoholic in order to suffer. Some persons are sadistic and must have someone available to punish. An alcoholic serves this purpose well. Others like to dominate and control other persons. Alcoholics provide a fit subject for exercising such control and dominance. If any of these three conditions exist, then the non-alcoholic may have a far more serious illness than alcoholism, and this must be treated and arrested before it is possible for this person to do other than contribute to the progress of alcoholism.

A wife, husband or family member needs to take a good look at his/her own involvement with the alcoholic before any steps should be taken to aid in abstinence from alcohol. In most instances a change in the family is necessary before a change in the alcoholic may be anticipated.

To do nothing is impossible. As a general rule, to do nothing means to give in to the situation, to be run over and exploited and to fight back in quiet, passive, destructive ways. The family always interacts with the alcoholic. The important thing is to learn which interactions are destructive and which might be creative and then have the courage to attempt a creative approach. The change must begin with the non-alcoholic. The alcoholic will not seek help in recovery as long as the alcoholic needs are met within the family.

LONG RANGE SOBRIETY

A frequent mistake is to attempt to protect the alcoholic from alcohol be bending every effort

to keep him away from the bottle and the bottle away from him. This cannot be achieved short of incarceration or commitment and even under these circumstances some manage to find alcohol. It is hard for the family to learn not to try to prevent the drinking, but any battle they win today over the bottle will be fought again tomorrow. Winning the war against the overall illness is the objective. Motivating the alcoholic to have a desire to stop drinking and to accept help in this effort are far more effective than trying to take the bottle away. The only way this motivation can be accomplished is by allowing the drinking and all its consequences to become so painful in itself that the alcoholic will seek escape from the intolerable pain caused by drinking. This means suffering, but suffering with him in pain of the consequences, not by becoming the means of his escape from consequences. This means the courage to suffer embarrassment, small or great, financial deprivation, loss of job, and in some instances temporary separation in various and sundry ways. We must offer greater joy in sobriety and allow the painful consequences to become acute if we anticipate ultimate long-range recovery.

Recovery from any serious illness may involve considerable time, and on occasions there may be relapses. The world has not come to an end if after a period of sobriety the alcoholic drinks again. If the family does not panic and revert to the former destructive means of dealing with the problem, the "slip" may be used to advantage and become an additional reason for the alcoholic to accept the fact that the first drink must be avoided.

THE ROLE OF AL-ANON

In the process of recovery, it is not possible to expect all that compulsive action disappear overnight. The alcoholic may become as engrossed in his treatment and recovery as he was a short time ago in the drinking.

This is especially true if he finds and accepts Alcoholics Anonymous. The alcoholic husband or wife may now spend each evening with these recovered alcoholics. The best bet against resentment in this area is for the spouse to join Al-Anon and attend open A.A. meetings. Al-Anon, the group for family members of the alcoholic, is just as vital to the emotional recovery of the family as A.A. is to the alcoholic. It attempts to provide insight and understanding into the problems of its own members. If a family wishes the drinking member to stop drinking and join A.A., they might first try Al-Anon and attend open A.A. meetings themselves. Recovery from alcoholism involves the healing of the emotional illness of all members of the family. If the alcoholic recovers emotionally and family members do not, there may be a serious breach in the family structure. The family must grow up emotionally before, during and after the alcoholic recovers, or serious estrangement may occur. The time for the family to begin working out their own emotional recovery is now.

BEGIN WITH SELF

The place to begin in helping an alcoholic recover is with self. Learn all you can. Put it into practice, not just into words. This will be far more effective than anything you attempt to do for the alcoholic.

In summation there are several rules of thumb which may be observed.

1. Learn all the facts and put them to work in your own life. Don't start with the alcoholic.

2. Attend A.A. meetings, Al-Anon meetings, and if possible go to a Mental Health Clinic, Alcoholism Information Center or to a competent counselor or minister who has had experience in this field. Go yourself, don't send the alcoholic.

3. Remember you are emotionally involved. Changing your attitude and approach to the problem can speed up recovery.

4. Encourage all beneficial activities of the alcoholic and cooperate in making them possible.

5. Learn that love cannot exist without compassion, discipline and justice, and to accept it or give it without these qualities is to destroy it eventually.

THE ALCOHOLIC'S WEAPONS

The first weapon is the ability to arouse anger or provoke loss of temper. If the family member or friend becomes angry and hostile, this person has been completely destroyed insofar as ability to help the alcoholic is concerned. Consciously or unconsciously the alcoholic is projecting an image of self hatred against the other person. If it is met by angry, hostile attacks, it is thereby verified and the alcoholic in his own mind justifies the former drinking and also now has an additional excuse to drink in the future. The gods first make angry those whom they wish to destroy, and the alcoholic has a long experience of acting like a little god. If your temper is lost, all chance of help at this time is thrown away, at least for the moment.

The second weapon of the alcoholic is the ability to arouse anxiety on the part of the family. Thereby they are compelled to do for the alcoholic that which must be done by the alcoholic if the illness is to be arrested and recovery initiated. A "bad check" is a good illustration for this principle. The check may be written before, during or after the drinking period. The alcoholic does not have money in the bank to redeem the check. When the anxiety of the family members becomes too intense as regards what will happen if the check is not redeemed, they secure money and cover the check. This relieves the anxiety of the family and the alcoholic, but it establishes a pattern for the alcoholic in the area of problem solving. The alcoholic now learns that his family is not going to let him suffer the consequences, and he may expect this to be done whenever a bad check is written.

More important still, if the check is redeemed by others, the alcoholic cannot redeem it, and therefore this failure is made permanent. The alcoholic cannot undo what others have already undone. This, in reality, increases the alcoholic's sense of failure and guilt, and increases the family's sense of hostility and condemnation of the alcoholic. Thereby, the alcoholic is doubly injured. The criticism, scolding and moralizing adds to the alcoholic's guilt and resentment against self and family. The entire situation is thus made worse. The family did not write the "bad checks", but "making it good" gave a form of approval but verbally condemned the same act.

Alcoholics are propelled along the progress of the disease when the family is unable to cope with anxiety aroused by the alcoholic. This is, in effect, part of the illness. Neither the alcoholic nor his family is able to face reality. The writing of the bad check and the redemption of it by the family are but two sides of the same problem. The alcoholic can never learn to solve his own problems in a responsible way if the anxiety of the family compels the removal of the problem before the alcoholic can be brought to face it and solve it or suffer the consequences. This "home training course" increases the alcoholic's irresponsibility, and thereby increases the hostility, resentment and tension between the "patient" and the family.

Anger and anxiety must be avoided by the family or the family contributes to the progress of the illness. The family members must first learn to cope with their own problems before any beneficial effects can reach the alcoholic. This requires help just as any serious illness requires help outside the family from doctors, nurses, etc. The alcoholic can continue to deny that he has a drinking problem and that he does not need help as long as the family, friends, ministers, doctors, lawyers or employer provide an automatic escape from the consequences of drinking.

Help for the alcoholic and for the family should be outside the circle of relatives, friends and neighbors. Preferably it should come from persons trained in this area of work or from experienced members of Alcoholics Anonymous or Al-Anon. Home remedies for alcoholism are notoriously injurious. The illness is so serious it will shorten human lives ten to twenty years if it goes unchecked.

LOVE AND COMPASSION

One of the more serious failures in approaching the alcoholic is the inability to understand the meaning of love. The wife has no more right to state, "If you loved me, you would not drink" than she has the right to say, "if you loved me, you would not have tuberculosis." Excessive drinking reveals the existence of the illness. Illness is a condition, not an act. It is not far from the truth that the alcoholic himself feels unloved and unwanted and not without reason. Love cannot exist without the dimension of justice. Love must also have compassion which means to bear with or to suffer with a person. Compassion does not mean to suffer because of the injustice of a person. Yet injustice is often suffered repeatedly by families of alcoholics.

Alcohol is an anesthetic. When the alcoholic drinks, he anesthetizes his pain. This is the pleasure of alcoholic escape. It is a problem solving device to relieve unpleasantness, anxiety, tension and resentment. When the alcoholic drinks, pain is avoided for the time being; but pain, tension, anxiety and resentment are increased severely in the family. When the alcoholic sobers up there is little desire to suffer the consequences of drinking. Remorse and guilt now compel the alcoholic to prostrate himself before the family, beg for mercy and promise that it will never happen again. Or the reverse side of the coin may appear, complete unwillingness to discuss what happened. Each attempt is to gain the same goal, the avoidance of the consequences of drinking. If the alcoholic succeeds by either means, his pain is again avoided or relieved, but the family again pays the price of the consequences of drinking.

SELF-CONCEPT

Self-concept is defined here as the total perception an individual has about him/herself. That is, being able to answer the questions, "Who am I?" and "Who am I in relation to others?"

Self-concept is enhanced when the individual has a strong, positve feeling of belonging and a sense of worth. These things can be fostered by providing activities which focus on various themes, including:

1. A person recognizes there are many individuals, yet realizes he/she is unique.
2. A person feels loved and can love.
3. A person is able to recognize and cope with his/her feelings and emotions.
4. A person can function in a group, yet is also comfortable being alone.
5. A person likes to and is able to do many things.
6. A person is able to successfully relate to the world about him/her.

We are all interested in ourselves. Realizing this, educators recommend that activities in school be related to the life experiences of the learner to maximize the efficiency and effectiveness of the learning process.

The question of the appropriateness of oneself as a topic of study within the school setting, however, remains. Since one behaves based on one's perceptions of reality rather than upon reality itself, one's perceptions of oneself will determine many health-related behaviors. For example, a person who is comfortable with him/herself will be better able to make a decision in the face of peer pressure on whether or not to drink and be less influenced by that pressure than a person with a poor self-concept.

As a result of the process of education, every student should feel that he or she is an important and worthwhile individual. At the same time, students should realize that they are not perfect and that change can be a very positive thing. Students should be able to identify both their strengths and weaknesses, while understanding that there may be limitations to what each person can achieve.

Within the context of the classroom, the teacher and the students should help each other realize the strengths they possess. Individuals should attempt to develop positive ways of interacting with other members of the class. Students in the class should feel free to ask questions, state their opinions or make observations without fear of reprisal, condemnation or ridicule. Similarly, students should feel free to be themselves, realizing their relationships within the class and respecting the rights and privileges of others. At all times, students and teachers must be sensitive to the feelings of each other. Every effort should be made to be positive when dealing with other people. Criticism can become an important part of the classroom environment when it is intended to be constructive rather than destructive.

CONCLUSION

As students begin to develop strong, positive self-concepts their abilities to make responsible decisions will improve. They will be better prepared to make decisions in their own best interests and in the interest of their fellow human beings.

Teachers can continually provide students with experiences which encourage them to incorporate the elements previously described into their own decision-making process. The process should be applied to a variety of different levels, ranging from major to minor decisions. This ability to practice will assist the student when faced with decisions to make outside the classroom.

The environment within the classroom is critical to the effectiveness of a comprehensive alcohol education program. How students interact with each other and the teacher will determine to what extent they will benefit from the classroom activities. Discussions of feelings, values, decisions and self-concept are likely to touch on areas that are very important to each student. The teacher and students must always keep in mind that each person has the right to his/her feelings and values, and that in many instances, there may be no "right or wrong" answers. Each person also has the option to "pass", that is, to choose not to share his/her feelings with others. The teacher must be especially careful about how he or she responds to students' comments and questions. If students feel that the teacher or other students will put them down for what they feel or believe, then they will seldom express their feelings and beliefs, thus missing an important part of the learning process.

Information, feelings, values, self-concept and decision-making must be dealt with repeatedly, beginning in most cases at the elementary levels. These five topics must also be considered in relation to each other. Each factor influences the others and the interrelationships must always be considered. As a result of the process of education, students should have a better understanding of the decisions they make and the factors which influence those decisions. That understanding should enable them to make more responsible decisions in the future.

CHEMICAL DEPENDENCY UNIT

PART III

Intervention and Recovery

Part III - Intervention & Recovery

Teacher Guide . . . . . III, 1
Jellnick's Chart of Recovery . . . . . III, 2
What Happens to An Alcoholic Before He Begins Recovery . . . . . III, 3-8
Worksheet . . . . . III, 9
Begin With Self & Some Don'ts . . . . . III, 10-11
An Outline of Intervention . . . . . III, 12-13
Test with Answer Key . . . . . III, 14-15
Do I Have a Problem with Chemicals . . . . . .III, 16
Teachers' Resource Material
Recovery . . . . . .III, 17
How To Help an Alcoholic Who Insists He Doesn't Need Any Help . . . . . III, 18-29
Student Evaluation of Unit . . . . . .III, 30
Teacher Evaluation of Unit . . . . . .III, 31

Part III – Intervention & Recovery

Teacher Guide

TEACHER PREPARATION – Read P. III, 17 to 31.

Day 1 – A. Quiz on Part II, The Family (The EWS for family and the five survival defense mechanisms).

B. Lecture on Fetal Alcohol Syndrome.

C. Show film, "Alcohol: Crisis for the Unborn", (16 minutes) and discuss.

D. Students copy and discuss "Recovery Half" of Jellnick's Chart (P. III,2).

E. Assign reading of "What Happens to an Alcoholic . . ." (P. III,3-8) and complete worksheet (P. III,9-Student Handout).

Day 2 – A. Discuss assignment.

B. Discuss "Begin With Self" and "Some Don'ts" (P. III,10 & 11). Stress availability of community resources. (A list is given on P. III,13.)

C. Distribute and discuss outline (P. III,12-13-Student Handout) and use it as a review for test. Stress the concept of chemical dependency as a disease with progressive symptoms. Discuss the necessity of an adequate diagnosis and recovery program, as with any other health problem. Mention the modes of treatment, including A. A. Review Jellnick's chart.

D. Assign final test on chemical dependency unit.

Day 3 – A. Prepare students for test.

B. Test (P. III,14-15-Student Handout).

C. Correct in class if desired.

D. At end of class give handout "Do I Have a Problem . . ." (P. III,16-Student Handout) and tell students to take home to complete.

Day 4 – Panel of Speakers. (Refer to Part IV for list of speakers and other information.)

As soon as possible after completion of the unit, ask the students to complete the "Student Evaluation of the Chemical Dependency Unit" (P. III,30-Student Handout)

Complete the "Teacher's Evaluation of Chemical Dependency Unit" (P. III,31-Teacher Handout) and give to the department chairman.

WHAT HAPPENS TO AN ALCOHOLIC BEFORE HE BEGINS RECOVERY?

The great puzzle of alcoholism has been – and is – how can those close to a victim of this illness motivate the sick man, or woman, to seek treatment and begin recovery.

What are the things that did motivate most of the alcoholics who are recovering? What changes must take place, mentally and emotionally, before a drinking alcoholic will stop denying the problem, cease pretending he isn't drinking, stop contending heatedly that he "can handle it all by himself" or attacking all those who try to discuss his obvious problems with drinking?

There are answers to these questions. They are being applied, in increasing numbers by both families and employers, with good to excellent results. The tragedy today is that too few families and employers know what to do. Some, even after they learn which steps have the best chance of leading their problem drinker to begin recovery, are unwilling, or for emotional reasons, are unable to think realistically and to begin realistic action. Too few physicians and clergymen, when asked for help, know what to tell the asker.

Out of the experience of thousands of alcoholics who have recovered, and their families and the many professional and other persons who have worked with them, four basic points emerge. At least three of these are found in virtually every recovery and often all four were present.

In working with over 4,000 alcoholics and/or families over the past nine years, the staff of the National Council on Alcoholism–Kansas City Area, has concluded that these points most often are the essentials to the beginning of recovery.

Without the first three, recovery almost never begins, or if it does start, it soon results in a relapse, or more frequently a series of slips, or returns to drinking. The four points are these:

1. THE ALCOHOLIC MUST LEARN AND THEN BELIEVE THAT HE HAS AN ILLNESS. A fatal, progressive disease that leads always to insanity or death if drinking continues. The train of symptoms is as clear and inexorable as those of pregnancy, once pregnancy has begun. A woman one week pregnant is no less pregnant because she doesn't know it, or can deny it, or is unable to get a medical diagnosis at such an early stage.

Alcoholism is similar except the span of the illness will average some 22 to 25 years instead of 9 months. Once problem drinking has begun (and it can be diagnosed earlier than pregnancy through behavior symptoms), it will pass through most of the 40 steps charted by the late E. M. Jellinek (see Roadmap of Alcoholism and Jellinek's 40 symptoms.)

Once the alcoholic can accept and believe that he is sick, rather than simply sinful, lacking will-power or is some kind of moral leper with weak character, he will begin moving toward the idea that he should get treatment appropriate for his illness.

It is a great emotional relief to him to learn that he is ill and that the American Medical Association and the American Hospital Association have all said, in effect, that he has a treatable illness that is within the purview of medical practice and that medical people should begin to assume their responsibilities in treating alcoholism.

2. THE PROBLEM DRINKER MUST BE GIVEN HOPE. He must learn and then believe

that recovery from alcoholism is possible and is something he can do because hundreds of thousands of other Americans, of all ages and backgrounds, have already done so.

One of the great beacons of light in the world of the alcoholic is the proof seen in Alcoholics Anonymous that all kinds of problem drinkers can and do recover. This beacon shines all over North America every night of the year as thousands of sober A.A.'s gather in hundreds of A.A. halls to continue their individual working of the 12 steps which are giving them back health and happiness.

One of the best ways any problem drinker, or anyone concerned about him, can learn this is to attend any open A.A. meeting as a visitor and see for himself. A.A. groups are listed in local telephone books or any local National Council on Alcoholism affiliate can provide information on the times and places of open A.A. meetings.

UNTIL THE PROBLEM DRINKER KNOWS AND BELIEVES THOSE TWO THINGS, that he is ill but can recover from this illness, no real attempt at treatment and recovery is very likely to begin.

3. THE ALCOHOLIC MUST FEEL THE FULL WEIGHT OF THE CONSEQUENCES OF HIS ILLNESS AS PAINFUL AS THESE MAY BE TO HIM AND THOSE WHO LOVE HIM. To over-simplify a bit, the problem drinker is much like a man with a toothache. As long as he can relieve the pain with aspirin or codeine or anything, he will put off going to the dentist. No matter that he knows he will have to go to the dentist eventually, that it is quite impossible to avoid forever the business of getting the tooth pulled or repaired, he will procrastinate and delay going, offer excuses and rationalize until the pain gets so great that he now both knows and believes (because pain drives him to that belief and convinces him more quickly and effectively than anything else on earth or in heaven can do) that he must go to the dentist now.

So, too, with the alcoholic. As long as his family is foolish enough to pretend he is not seriously sick, as long as they treat him like a child (while failing to recognize how emotionally childish he is) by covering up for him with his boss, with friends and relatives, so long as they bail him out of jail, help cover his bad checks, excuse his anti-social behavior – he will do the only thing that is logical from his point of view – he will avoid seeking treatment for his alcoholism, and he will continue drinking.

He won't go near the dentist.

Why should he?

Everyone is helping ease the pain of his toothache for him.

When his earnings drop or job trouble begins, his wife goes to work or borrows money and this eases his toothache again. So he still avoids the dentist. You would, too, in his place. Anyone would. All alcoholics do!

The employer (or law or business partner or fellow physician) who watches a valued colleague or employee slide painfully down the drain into chronic alcoholism and takes no action, or issues a long series of lectures and "final warnings" which he doesn't believe himself (nor does the alcoholic believe them) is simply paying a premium to the problem drinker to continue further and deeper into alcoholism. Such a partner or employer is encouraging by his action (although he pretends to disapprove by words) the alcoholic to continue drinking.

They are helping make possible the slow descent into death or insanity of one who is clutched in what Dr. Karl Menninger defines as "the most painful form of suicide" because it takes so long and damages so many people around each alcoholic.

Why go to the dentist if other people keep easing his toothache for him?

Why ask for treatment when his boss is willing to subsidize his alcoholic drinking?

Until he has been allowed to feel the painful consequences, no alcoholic in history has taken any effective steps toward recovery.

He may make promises, on his "dying oath", his mother's grave or a stack of family Bibles, but he will continue to drink and will continue to manipulate the wife, boss or others who are silly enough to play patsy (or dummy) for their alcoholic.

Dozens of experts have pointed out the total futility of hesitating or waiting to act, of accepting promises instead of requiring action or of continuing to rush to his rescue "because I can't bear to see him suffer so". These authorities, and thousands of recovered alcoholics, are virtually unanimous in their statements that such futile procedures will have only one possible result – they will enable the alcoholic to get sicker.

This point was reinforced recently by a man who came back with his wife and two children to our Alcoholism Information Center. It had been two years since his wife had come in, near despair. Her husband, age 42, had been in and around A.A. for almost 19 years and never gained much sobriety and now was a major problem and rapidly getting to be unemployable. The husband had learned Steps 1 and 2, but she had protected and excused him. We pointed out her mistake and she acted. First, she attacked the 7-week Family Discussion Group course. Later her husband came back to tell us:

I've got a steady job now and have been going to the university to get my graduate degree so I can get a better job. The best thing you taught my wife down here was to kick me out. That made me take real action for the first time. And I can't tell you how grateful I am for that."

This story is in our confidential case records in hundreds of variations of alcoholic husbands, wives, parents, children and employees.

4. IF STEPS 1, 2 AND 3 HAVE BEEN COMPLETED AND RECOVERY HAS NOT BEGUN, THE ALCOHOLIC MUST BE PRESENTED AN INESCAPABLE CHOICE BETWEEN HIS DRINKING AND HIS FAMILY OR HIS DRINKING AND HIS JOB– PREFERABLY BOTH AT THE SAME TIME.

If family and/or employer take action because of anger, hostility or to punish the alcoholic, to "teach him a lesson," to "straighten out his moral outlook" or to "get even with that slob", all their efforts will very probably fail. Their alcoholic will clearly see and feel their hostile emotions, no matter what they may say, and will react to these EMOTIONS BY GETTING DRUNKER AND SICKER.

If failure of such choice presenting ultimatums is to be avoided, then the family and/or employer must act from true concern or love for the sick problem drinker, must talk in direct, blunt words, must avoid all digressions into reasons why he drinks, or how seldom or how often he drinks, and present a roadway that has only two branches recovery or drinking.

They cannot accept any promises, however sincere or tearful or heart-tugging. Only effective action can be accepted.

Companies that have adopted such policies of dealing with alcoholics, whether blue collar men, stenographers or top executives, have experienced recovery rates of 60 to 85%.

Families who do so, in the right way, run even higher recovery rates but it is harder and rarer for families to avoid hatred, hostility, punitive feelings and lecturing and moralizing. When family and employer act together in a kindly but toughly firm and consistent way, recovery is closer to 100 per cent.

The reason that 9 out of 10 American alcoholics today die of their illness if that too few employers and even fewer families ever really try these actions which have a good chance of working.

Their failure to act, the failure of professionals and other helpers to teach them what can be done, presently puts millions of victims of alcoholism under sentence of slow and painful death.

CONFRONTATION WITH HOPE

"An alcoholic cannot be helped until he wants help. He must be ready. He must have an honest desire to quit drinking." Time and time again, we hear these statements. We still see them in print despite the fact that alcoholism therapists are telling us that this is a delusion. They are saying that we should not sit around waiting for the alcoholic to acquire an honest desire to quit drinking. We must and can help him get this desire. We can help him to want help.

When all is said and done, the alcoholic is motivated to some sort of concern for his drinking only when the pain he gets from drinking outweighs the reward. As long as alcohol is working satisfactorily, as long as he is getting reward without too much pain, why should he quit?

We've known this for a long time. But we have too often just sat around letting nature take its course. We have watched a man lose his family, his job, his self-respect, his health, everything that is near and dear to him, as alcoholism pursues its relentless course. We have said to ourselves that the time will eventually come when he will be hurting so badly that out of sheer desperation he will seek help for his drinking. We have justified our inaction by saying that we can't do anything until this happens.

What is so wrong about this procedure is that at this point he has lost so many of the resources he needs for recovery. He has lost an important resource within himself, namely, the ability to make rational decisions. He has retreated behind such a massive facade of rationalization, projection, delusion, and denial that irrational thinking has become a way of life. He is no longer able to even begin to analyze his problem in a rational way. He has also lost so many resources outside himself. His family is gone. His job is gone. His work record is bad. He has lost his self-respect. His health is impaired. Goals and dreams are shattered. Life becomes meaningless. There is little left to motivate him to pursue the long arduous road to recovery. Confrontation at this stage often turns out to be confrontation without hope.

Instead of this self-defeating process, families need to learn that there is such a thing as earlier confrontation with hope – that there is such a thing as applying the pain sooner.

I. The first step in this process is to let the alcoholic accept the consequences of his drinking. Families have a tendency to do just the opposite. In their desperate effort to cover up the "disgrace" that has befallen the family, they adjust their whole way of living to the drinking pattern of the alcoholic. They allow the alcoholic to provoke them to anger and to arouse their anxiety to the point where they themselves are accepting the consequences of his drinking. The sooner the alcoholic is forced to deal with these consequences himself, the sooner will the pain of his drinking over-balance the reward he gets from it.

II. There are many ways in which the family, the employer, and other meaningful people can be effectively involved in the confrontation process, but they can do this only after they have taken a critical look at themselves. They must not only have a clear understanding of the nature of alcoholism, but they must work through their own feelings, attitudes and defense systems. Otherwise, confrontation can turn out to be simply condemnation and rejection, which drives the alcoholic farther into his illness.

III. The alcoholic can be helped to want help. Crisis and alternatives can be created that can drive the alcoholic into treatment not because he wants to quit drinking, but because he

has no other alternatives that are acceptable to him. At this point, he may not want help to stop drinking. He may only want help to get the bill collectors off his back or to avoid other undersirable consequences of his drinking. He may not want to recognize himself as an alcoholic. It is then up to the therapist to help him break through his irrational thinking and his defense mechanisms that prevent him from coming to grips with his alcoholism. This is part of treatment.

Confrontation with hope is the process of helping the alcoholic to want and to seek help while there is hope of saving what he holds dear in life. There are ways of doing this if meaningful people will take the time to learn how.

Worksheet - What Happens to an Alcoholic Before He Begins Recovery

1. What is the great puzzle of alcoholism?

2. Name the three points that are essential to the beginning of recovery. Explain each!

   A.

   B.

   C.

3. Why does Dr. Menninger call alcoholism the most painful form of suicide?

4. What is the fourth step to recovery. Explain fully!

5. What % of American alcoholics die of their illness? Why?

6. Explain why the following statement is false. "An alcoholic cannot be helped until he wants help!"

7. What motivates the alcoholic to quit drinking?

8. Name 3 resources within himself, the alcoholic loses if we wait for nature to take its course before we confront the alcoholic.

   1.

   2.

   3.

9. Name 5 resources outside himself.

   1.

   2.

   3.

   4.

   5.

10. Confrontation with hope simply means –

11. Name three steps you can take to help bring about an earlier confrontation with hope. Explain each!

    A.

    B.

    C.

12. Define Confrontation with hope.

BEGIN WITH SELF

The place to begin in helping an alcoholic recover is with self. Learn all you can. Put it into practice, not just into words. This will be far more effective than anything you attempt to do for him (her).

There are several rules of thumb which may be observed:

1. Learn all the facts and put them to work in your own life. Don't start with the alcoholic.

2. Attend A.A. meetings, Al-Anon meetings, and if possible go to a Mental Health Clinic, Alcoholism Information Center, or to a competent counselor or minister who has had experience in this field. Go yourself, don't send the alcoholic.

3. Remember you are emotionally involved. Changing your attitude and approach to the problem can speed up recovery.

4. Encourage all beneficial activities of the alcoholic and cooperate in making them possible.

5. Learn that love cannot exist without compassion, discipline and justice, and to accept it or give it without these qualities is to destroy it eventually.

It is easier to find a list of dont's in dealing with alcoholics, for it is easier to understand why you fail than to know why you succeed. The following list is not inclusive, but it makes a good beginning.

SOME DONT'S

1. Don't allow the alcoholic to lie to you and accept it for the truth, for in so doing you encourage this process. The truth is often painful, but get at it.

2. Don't let the alcoholic exploit you or take advantage of you, for in so doing you become an accomplice in the evasion of responsibility.

3. Don't let the alcoholic outsmart you, for this teaches him to avoid responsibility and lose respect for you at the same time.

4. Don't lecture, moralize, scold, praise, blame, threaten, argue when drunk or sober, or pour out liquor. You may feel better, but the situation will be worse.

5. Don't accept promises, for this is just a method of postponing pain. In the same way, don't keep switching agreements. If an agreement is made, stick to it.

6. Don't lose your temper and thereby destroy yourself and any possiblity of help.

7. Don't allow your anxiety to compel you to do what the alcoholic must do for himself.

8. Don't cover up or abort the consequences of drinking. This reduces the crisis but perpectuates the illness.

9. Don't try to follow this as a rule book. It is simply a "guide" to be used with intelligence and evaluation. If at all possible, seek good professional help. You need it as well as the alcoholic.

10. Above all, don't put off facing the reality that alcoholism is a progressive illness which gets increasingly worse as drinking continues. Start now to learn, to understand and to plan for recovery. To do nothing is the worst choice you can make.

Phase I The Preparation

1. Know the illness
   Examine your own attitudes
   Know the symptoms
   Learn the prognosis or outcome

2. Understand recovery

   Know how it works - recovery is a process, not a condition.

   a. The alcoholic must accept the fact of his condition; that he suffers from a chronic but treatable disease.

   b. He must stop drinking although abstinence is not all there is to recovery.

   c. He must become willing to do what is necessary to aid his recovery.

   d. He must achieve some long range adjustment in his self-understanding and an ability to accept himself and life for what they really are.

   Have a plan that looks toward full recovery.

3. Beware of your own emotional involvement.

4. Don't argue - especially over the drinking.

Phase II The Surround (Cut off all exits)

1. Don't present a minority view
   Stop covering up
   Enlist some help
   Talk to his boss
   Count your advisors in

2. Set up the confrontation

   Timing is critical

   Not drunk or hungover

   Soon after a crisis

   Spell out the problem and solution calmly and clearly

   a. Diagnosis - symptoms and examples

   b. Prognosis - what will happen

   c. Plan for recovery

   Do not threaten or try to bluff. You must be prepared to follow through.

3. Offer hope

25074

4. Push in one direction only
   Do not bargain or debate
   Do not relent or give up
   Set deadlines with care

Phase III Follow Through

1. When he agrees to accept treatment

   Follow deadlines, be consistent.
   Forget the past.
   Live the present.
   Credit the future.

2. If he refuses the treatment plan

You must accept the prognosis yourself and begin to apply the appropriate course of action. You can't help a sick man by deciding that he isn't sick; wishing won't make him well, and if you back away from the facts you have presented, he will make the decisions, in perverse triumph, that he or his rationalizations were right all along.

If he doesn't respond right away, or if he makes only a gesture at accepting help, it will be because he doesn't believe you. It will mean that he hasn't accepted the fact of his condition.

He may respond a little later, when the prognosis you have given him begins to come true, especially if he sees that you are adjusting your own life on the assumption that, without help, he will probably get much worse.

In the meanwhile, go back to your advisors and review with them what you have done. No case of alcoholism becomes hopeless until those who would help the alcoholic don't want to try any more. Even if there are no more promising approaches to be tried, then you will at least have helped in facing some decisions on your own future which ought not be delayed.

Remember: The worst thing you can do is nothing.

The best thing you can do is to first get some information and help for yourself.

Local Resources:

Omaha Area Council on Alcoholism
2222 California Street
345-4080

Chemical Dependency Unit
Eppley
Methodist Hospital
3612 Cuming Street
397-3150

Al-Anon Information Service
124 South 24th Street
345-2414

Alcoholics Anonymous
Central Office
4412 Farnam Street
553-1964

Name _____

ALCOHOLISM

What are the three traditional viewpoints or definitions of alcoholism?

1. *Moral weakness*
2. *Psychological problem*
3. *A disease*

Give three reasons that alcoholism can be considered a disease.

4. *It has symptoms*
5. *The symptoms are progressive*
6. *It can be diagnosed & treated*

7. Define "alcoholic".
   A person whose drinking causes repeated problems in any area of his life.
8. Give an example of a statement of denial that an alcoholic might make.
   "Everybody drinks on Friday night. My drinks just seem to hit me harder."
9. Give an example of a statement of denial that the friend or family member might make.
   "Mary doesn't have a drinking problem. She's just been under a lot of stress lately."
10. What is the first thing a friend or family member should do to help an alcoholic?
    Get help for themselves.

List the three phases of intervention.

11. *Preparation*
12. *The Surround*
13. *Follow through*
14. Give one of the typical home remedies that the family may try.
    1) Pour liquor out. 2) Coax promises. 3) Say: Act like a man! Don't you love me?

List three of the five survival defense mechanisms.

15. *Chief Enabler* *Lost Child*
16. *Family Hero* *The Mascot*
17. *Scapegoat*

Fill in the blank.

18. In *1956* (year) the American Medical Association agreed that alcoholism should be treated as a disease.

19. When a person *passes out* from drinking too much alcohol, he or she loses consciousness.

20. A *black-out* is a temporary loss of memory during a period of drinking alcohol.

21. Increased *tolerance* is a symptom of the early stages of alcoholism.

True or False.

23. *F* All alcoholics drink on a daily basis.

24. *F* Most alcoholics are on Skid Row.

25. *T* An alcoholic is a person whose drinking causes repeated problems in any area of life.

26. *T* About one out of every ten people who drink will become alcoholic.

27. *T* Some people who become alcoholic drink normally for several years before the symptoms of the disease show up.

28. *F* Alcoholics can stop drinking if they use their willpower.

29. *T* Many people believe alcoholism is a moral or psychological problem.

30. *T* Alcoholism can strike a person regardless of age, sex, religion, education, or economic or social position.

List five of the early warning signs of alcoholism.

31. *unusually high tolerance to alcohol*

32. *lapse of memory when drinking*

33. *guilt or remorse after drinking*

34. *drinking alone*

35. *marked personality change*

List five of the early warning signs of alcoholism for the family.

36. *occasional doubts about alcoholics drinking*

37. *rationalizing alcoholic's behavior*

38. *unable to discuss the problem*

39. *feels guilty and responsible for alcoholic's drinking*

40. *begins doubting own perceptions & memory*

DO I HAVE A PROBLEM WITH CHEMICALS? *Student Handout*

QUESTION	YES	NO
1. Do you lose time from work or school due to drugs?	____	____
2. Are drugs making your home life unhappy?	____	____
3. Do you use drugs because you are shy with other people?	____	____
4. Are drugs affecting your reputation?	____	____
5. Have you ever felt remorse after using drugs?	____	____
6. Have you gotten into financial difficulties as a result of drugs?	____	____
7. Do you turn to lower companions and an inferior environment when using drugs?	____	____
8. Does your use of chemicals make you careless of your family's welfare?	____	____
9. Has your ambition decreased since using chemicals?	____	____
10. Do you crave chemicals at a definite time daily?	____	____
11. Do you want a chemical in the morning?	____	____
12. Does using chemicals cause you difficulty in sleeping?	____	____
13. Has your efficiency decreased since using chemicals?	____	____
14. Are drugs jeopardizing your job or business - or school?	____	____
15. Do you use drugs to escape from worries or troubles?	____	____
16. Do you use chemicals alone?	____	____
17. Have you ever had a complete loss of memory as a result of using drugs?	____	____
18. Has your physician ever treated you for drug abuse?	____	____
19. Do you use drugs to build up your self-confidence?	____	____
20. Have you ever been to a hospital or institution on account of chemicals?	____	____

If you have answered Yes to any of the questions, there is a definite warning that you may be a chemical abuser.

If you have answered Yes to any two, the chances are that you are a chemical abuser. For help, see your school counselor or call the Omaha Area Council on Alcoholism (OACA) at 345-4080.

25074

RECOVERY

Recovery from chemical dependency depends greatly on the motivation of the individual. The first step is an honest desire for help, usually after powerlessness over the drug is admitted. This truism does not mean that attempts to interrupt and treat the disease are ineffective. An intensive in-patient treatment setting is often effective in tearing down the denial systems (rigid negative attitude, rigid defense system, low self-esteem, etc.) The denial system tells the problem drug user that he/she can control or handle the drug – if . . . Recovery necessitates total abstinence! To successfully get off and stay off all mood altering chemicals usually takes outside help.

AA came about in the 1930's to help people stay sober. The foundation of AA's programs can be paraphrased as "I can't" (handle the drug or my life), "He can" (God, and/or other people, the support group, etc.), "I think I'll let Him." In other words,

ADMITTED UNMANAGEABILITY IN HANDLING THE DRUG OR LIFE
BECAME WILLING FOR HELP
ACCEPTED OUTSIDE HELP
FOLLOWED A COURSE OF RECOVERY

AA has worked best for most and remains the surest way to maintain a "happy" sobriety or straight life. Some individuals cannot decide to give up all drugs or "forever" give up a drug. The AA program says "one day at a time." Slips or returning to drug use may occur but not to all. There is ALWAYS hope! Many people cannot admit it's "that bad." Others may not get help no matter how obvious the problems are. Therefore, there is a need to "help" motivate the alcoholic or chemically dependent person. AA is not always the answer initially. Professionals in many walks of life – the legal system, health field workers, the clergy, etc., – those who understand the disease can guide the chemically dependent person to the treatment route appropriate for his/her case.

Modes of treatment are varied. For many, medical detoxification in an in-patient hospital and/or treatment center is indicated. In-patient treatment centers boast a high rate of recovery due to long term, intensive programs designed specifically for all drug related problems of dependency. Out-patient counselling is a mode of treatment that works for many but requires total abstinence before, during, and after therapy.

There are individuals who draw upon spiritual or religious means to remain comfortably sober and serene. Still, there are individuals who have kicked the habit, are temporarily or permanently on the wagon, often unhappy, uncomfortable, and continuing with the same attitudes and behaviors as exhibited in their using days. They are often referred to as "dry drunks" and they need help!

The chemical addiction – physical and mental dependency – is only "part" of the problem. A large share of the problem is the maladjustment due to learned, chemically distorted coping skills and life perceptions.

HOW TO HELP AN ALCOHOLIC WHO INSISTS HE DOESN'T NEED ANY HELP

This description, both research and common sense will tell us, fits by far, the vast majority of alcoholics in any community today.

For one thing, it is part of the obsessive nature of the illness that the alcoholic usually believes there is nothing so wrong with his drinking that he can't, somehow, handle it himself. And even now, many of us persist in the notion that an alcoholic is one of society's uglier specimens, an unloved and graceless wretch beyond either hope or help. Few of us want to admit we are married to, neighbors of, or work with one of them.

So all too often, those closest to the alcoholic – his family, friends and working associates – are inclined to go along with the sick man's diagnosis of his own condition. If they don't like his drinking or what it leads to, they ask him to stop – as if he could.

Even those who have set themselves up to aid the alcoholic to recovery tend to withhold their help until the alcoholic says he is ready to accept it. This applies not only to Alcoholics Anonymous, which has probably helped more to recovery than all other treatment resources combined, but to clinics and hospitals as well. Most modern in-patient treatment facilities for alcoholism have voluntary admission policies and will not (with good reason) accept involuntary commitments.

Thus, getting the alcoholic to become willing to involve himself in treatment – a process we call motivation – is the most crucial step in recovery.

MOTIVATION: CAN IT BE DONE?

Obviously, it can be accomplished somehow or no recoveries would be possible at all. Much more appropriate questions, therefore, are these: Can it be induced? Should it be attempted? Who can do it? When should it be tried: And how can it be done?

Before we tackle the answers, we'd better define our terms.

ALCOHOLISM: A DEFINITION IN DEPTH

A consensus of medical and psychiatric opinion, broadly based on both research and clinical experience, agrees that alcoholism is a chronic and progressive illness, disease or disability, with both physical and psychological aspects. It is characterized by the victim's abnormal drinking behavior and his apparent inability to control his drinking.

The physical aspect is a form of addiction, sometimes including withdrawal symptoms, usually manifest by a compulsion to continue drinking, triggered by a certain amount of alcohol in the body.

The psychological aspect is an obsession with drinking, even when "dry", and includes a rationalized self-image that enables the alcoholic to lay all his troubles to causes other than his drinking or himself.

Neither the exact causes of the illness, nor the changes it brings about in the body are completely understood. And that means it cannot be prevented. Nor can it be cured, in the sense that an alcoholic can ever expect to return to a pattern of "normal" drinking.

AN ALCOHOLIC: A PRACTICAL DEFINITION

An alcoholic is someone whose drinking causes continuing problems in any department in his life – in his family relationships, his financial affairs, his ability to work effectively or to get along with people.

The key word here is continuing. Most rational people react to a pattern of problems by cutting down or eliminating whatever causes them. So it is exactly the alcoholic's apparent inability to cut down on his drinking – in spite of the trouble it causes – that distinguishes him from other drinkers. Research suggests that there are more alcoholics around than most of us realize.

MOTIVATION: HOW IT HAPPENS

Probably the clearest and most comprehensive portrait of the progression of the illness in an alcoholic is that drawn by the late Professor E. M. Jellinek, one of the founders of the Yale (now Rutgers) Center of Alcohol Studies. Jellinek based his original work on an analysis of more than 2,000 drinking histories of alcoholics, including many recovered in A.A.

In brief, Jellinek's chart of 43 symptoms describes how, as the alcoholic grows more dependent on the effects of drinking, he has to rationalize, conceal or explain away his behavior, often to satisfy himself but usually in response to criticism or questions from those around him.

The excuses and explanations are modest at first, but as the drinking and the problems increase, the rationalizations tend to multiply and become much more elaborate, evolving into what Jellinek, in a wonderfully descriptive phrase, called the alibi structure. (AA's informal term is more pungent: "stinking thinking.")

The process of rationalization grows with the progress of the illness, which may cover a span of twenty years or more. It starts in the prealcoholic stage (when the drinker begins to drink for relief rather than for social reasons), continues through the early stage (when memory blanks from only moderate bouts begin to occur), grows in the middle stage (when drinking tends to become uncontrolled once begun) and carries into the last stage (marked by prolonged binges.)

Finally, the facts of what life has become get impossible to explain away: the alibi structure collapses. Now the alcoholic, in Jellinek's words, " . . . becomes spontaneously accessible to treatment."

This idea is paralleled in the AA concept of "hitting bottom," frequently cited as a necessary preliminary to successful recovery. And the process, as seen by the alcoholic himself, is clearly stated in the wording of the first of the Twelve Steps of AA: "We admitted that we were powerless over alcohol – that our lives had become unmanageable."

MOTIVATION: CAN IT BE INDUCED?

Says Jellinek: "Formerly it was thought that the addict must reach this stage of utter defeat in order to be treated successfully. Clinical experience has shown, however, that his "defeat" can be induced long before it would occur of itself and that even incipient alcoholism can be intercepted. Since the incipient alcoholic can be easily recognized, it is possible to tackle the problem from the preventive angle."

The notion that the bottom might be induced (and a hint of how it might be done) is also

clearly suggested by Bill S., one of AA's co-founders. "Why," he asks, "should an alcoholic have to wait until he is 55 and horribly mangled to find out that he is a very sick man, when enough education of the right kind might have convinced him at 30 or 35?"

"The potential alcoholic will have to be surrounded by true and deep understanding and by a continuous barrage of information: the facts about his illness, its symptoms, its grim seriousness."

Others have argued that motivation not only can but should be induced. Professor Harrison M. Trice of Cornell suggests that "pre-AA" treatment efforts can reduce the barriers to acceptance of the AA program; and Herman E. Krimmel, Director of the Cleveland Center on Alcoholism, has urged the therapeutic benefits of "creating a crisis" in the life of an alcoholic, in order "to raise the bottom to break his fall as soon as possible.

MOTIVATION: SHOULD IT BE ATTEMPTED?

If motivation is the most crucial step in recovery from alcoholism, then providing motivation is an essential part of treatment. And unless it is attempted by those who would help the alcoholic, then it can only be accomplished, accidentally if at all, by the deteriorating progress of the disease itself.

There is no justification – in law, in medicine, or in any other code of human conduct – for such a hands-off approach to such a seriously damaging condition. If alcoholism is indeed an illness, then, as with all other illnesses, the earlier treatment begins the greater is the hope and the easier is the recovery.

MOTIVATION: WHO CAN DO IT?

Motivation is partly a process of collapsing the alibi structure, in order to get the alcoholic to accept the need for treatment. Logically, it is a task to be undertaken by those closest to the alcoholic – his family, friends, and working associates – for whose benefit the alibi structure was largely erected in the first place.

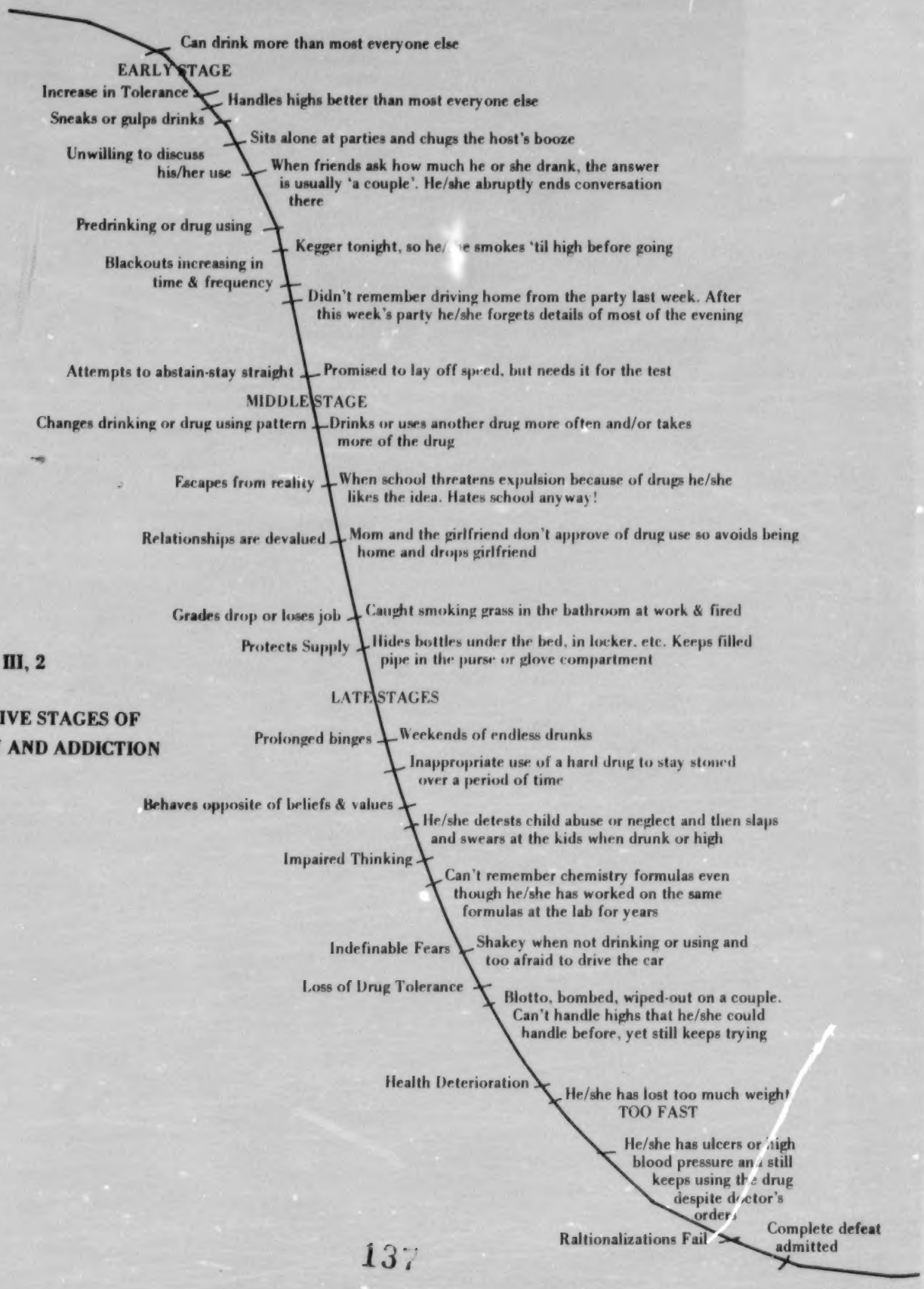
But their success in this effort will depend entirely on how well they understand the illness. Motivation, therefore, is something to be done by those closest to the alcoholic, with explicit and continuing advice from someone who understands thoroughly not only the illness of alcoholism but the process of recovery as well.

MOTIVATION: WHEN SHOULD IT BE TRIED:

This first step should be taken as soon as possible. As a practical matter, it is not likely to be attempted until there has been enough deviant drinking behavior to justify a presumption of at least incipient alcholism.

But it must be a "pre-treatment" effort, brought to bear on the alcoholic while he is still on his home grounds, in what he regards as his normal life situation, and whether he thinks he is "ready" or not.

Research from many sources indicates that first attempts at formal treatment, whatever the method, are often unsuccessful. Thus, the fact that formal treatment resources, including AA, do not attempt motiviation is not an argument that motivation won't work. Rather, it is a reflection that AA, clinics and hospitals have learned – often the hard way – that motivation is a step which they don't accomplish easily or alone.

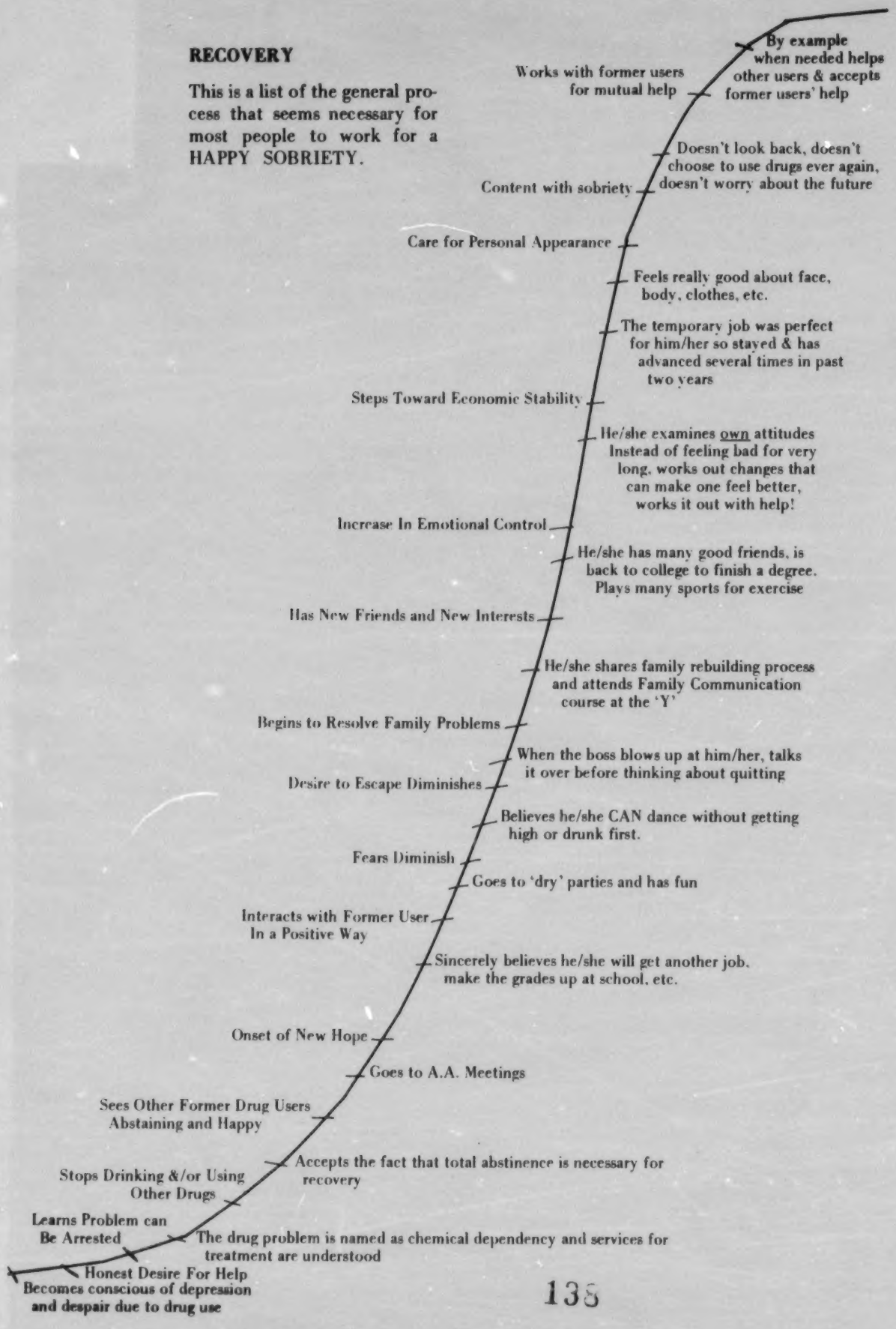

Can drink more than most everyone else
EARLY STAGE
Increase in Tolerance
Handles highs better than most everyone else
Sneaks or gulps drinks
Sits alone at parties and chugs the host's booze
Unwilling to discuss his/her use
When friends ask how much he or she drank, the answer is usually 'a couple'. He/she abruptly ends conversation there
Predrinking or drug using
Kegger tonight, so he/ e smokes 'til high before going
Blackouts increasing in time & frequency
Didn't remember driving home from the party last week. After this week's party he/she forgets details of most of the evening
Attempts to abstain-stay straight
Promised to lay off speed, but needs it for the test
MIDDLE STAGE
Changes drinking or drug using pattern
Drinks or uses another drug more often and/or takes more of the drug
Escapes from reality
When school threatens expulsion because of drugs he/she likes the idea. Hates school anyway!
Relationships are devalued
Mom and the girlfriend don't approve of drug use so avoids being home and drops girlfriend
Grades drop or loses job
Caught smoking grass in the bathroom at work & fired
Protects Supply
Hides bottles under the bed, in locker, etc. Keeps filled pipe in the purse or glove compartment
LATE STAGES
Prolonged binges
Weekends of endless drunks
Inappropriate use of a hard drug to stay stoned over a period of time
Behaves opposite of beliefs & values
He/she detests child abuse or neglect and then slaps and swears at the kids when drunk or high
Impaired Thinking
Can't remember chemistry formulas even though he/she has worked on the same formulas at the lab for years
Indefinable Fears
Shakey when not drinking or using and too afraid to drive the car
Loss of Drug Tolerance
Blotto, bombed, wiped-out on a couple. Can't handle highs that he/she could handle before, yet still keeps trying
Health Deterioration
He/she has lost too much weight
TOO FAST
He/she has ulcers or high blood pressure and still keeps using the drug despite doctor's orders
Raltionalizations Fail
Complete defeat admitted

III, 2

PROGRESSIVE STAGES OF DEPENDENCY AND ADDICTION

RECOVERY

This is a list of the general process that seems necessary for most people to work for a HAPPY SOBRIETY.


By example when needed helps other users & accepts former users' help
Works with former users for mutual help
Doesn't look back, doesn't choose to use drugs ever again, doesn't worry about the future
Content with sobriety
Care for Personal Appearance
Feels really good about face, body, clothes, etc.
The temporary job was perfect for him/her so stayed & has advanced several times in past two years
Steps Toward Economic Stability
He/she examines own attitudes Instead of feeling bad for very long, works out changes that can make one feel better, works it out with help!
Increase In Emotional Control
He/she has many good friends, is back to college to finish a degree. Plays many sports for exercise
Has New Friends and New Interests
He/she shares family rebuilding process and attends Family Communication course at the 'Y'
Begins to Resolve Family Problems
When the boss blows up at him/her, talks it over before thinking about quitting
Desire to Escape Diminishes
Believes he/she CAN dance without getting high or drunk first.
Fears Diminish
Goes to 'dry' parties and has fun
Interacts with Former User In a Positive Way
Sincerely believes he/she will get another job, make the grades up at school, etc.
Onset of New Hope
Goes to A.A. Meetings
Sees Other Former Drug Users Abstaining and Happy
Accepts the fact that total abstinence is necessary for recovery
Stops Drinking &/or Using Other Drugs
Learns Problem can Be Arrested
The drug problem is named as chemical dependency and services for treatment are understood
Honest Desire For Help
Becomes conscious of depression and despair due to drug use

The explanation for this lies in the way the rationalization power of the alcoholic works. Even as a patient in an alcoholism hospital, it is a relatively easy thing for him to explain away his current situation.

"I don't belong here", a typical line of thought would be. "These are all very nice people who have a lot of interesting things to say. But none of it applies to me. I'm here only to quiet my wife, who doesn't understand me and is unreasonably worried about my drinking. Soon, however, I'll be out of here and then I will get things back to normal".

MOTIVATION: HOW IT CAN BE DONE

Before the alcoholic will accept the need for treatment, he must become surrounded by the truth of his condition. "Surround" is used here as in a military sense: the maneuver must be planned well enough to preclude escape and to ensure the "continuous barrage of . . . the facts about his illness, its symptoms, its grim seriousness".

The effort, therefore, must be carefully planned. Then the plan must be carefully carried out. On the following pages we present a general outline which presumes that the effort will be organized by a member of the alcoholic's family. However, the circumstances of individual cases vary enormously and for that reason, before any step is considered, the family should get explicit and competent advice, particularly on such matters as unsuspected medical or psychiatric complications and the availability and appropriateness of nearby treatment resources.

PHASE I: THE PREPARATION

1. Know the illness

You are not likely to convince an alcoholic that he's sick enough to need help unless you really believe, yourself, that he is sick and know enough about the illness to be able to argue the case convincingly. This will require, at the least, some reading and listening on your part.

Accept the implications of the illness concept completely. This may be a fairly new idea for you that will take a little getting used to. If he's sick, then will power, lectures or "if-you-really-loved-me" pleas won't do any good.

Learn the symptoms well enough that you can show him clearly and briefly how his behavior fits into the progressive pattern of the illness. But the symptoms you cite must be based on greater authority than your own opinion, or they will have little influence on him.

Know the prognosis of what will probably happen to him and the family if he doesn't recover. This is not likely to be a pleasant prospect, for the stunted careers and unemployment, multiplying debt, suicide, and lives otherwise shortened (an average of 12½ years) by deteriorating physical health or accidental death. Don't doubt the reality of these grim alternatives, for you will find them thoroughly documented in the professional literature. And informal corroboration is usually available at any nearby open meeting of AA.

2. Understand recovery

Know how it works. Recovery is a process, not a condition. There are several methods of treatment: physical medicine, psychiatry, AA, drugs and spiritual counseling. Usually they are used in some combination. But whatever the method, there are four essentials to any recovery:

1. The alcoholic must accept the fact of his condition: that he suffers from a chronic but treatable illness.

2. He must stop drinking although abstinence is not, by a long shot, all there is to recovery.

3. He must become willing to do what is necessary to aid his recovery.

4. He must achieve some long range adjustment in his self-understanding, a continuing ability to accept life and himself for what they really are.

Have a plan that looks toward the full process of recovery. Fit the plan to the likelihood of the kind of treatment he will need. If he has been mixing his drinking with pills or drugs, then immediate hospitalization may be in order. If he has considered suicide or has shown signs of severe depression, then psychiatric evaluation may be a must. On this phase of the plan, it is particularly important to seek competent advice.

Don't settle for a one-step plan, a quick drying-out. Learn about specific facilities and which are most appropriate to his particular case. Recognize that there are still gaps in professional education on alcoholism so that whom you consult, in any profession, can be crucial.

3. Beware of your own emotional involvement

You cannot help him if you act in anger or from pent-up resentment. Punishment isn't treatment. Efforts to get even will only build resentments and justify his rationalizations.

Over the years, he may well have provided you with ample reason for being mad or fed up or heartsick with disappointment. But you must understand that the symptoms of this illness are primarily behavioral: his infuriating attitudes and actions are proof that he's sick.

If necessary, delay doing anything until you can look past these symptoms. Plan only when you can be objective. Act only when you know you can do so with calm resolution.

4. Don't skirmish – especially over the drinking

Discard the short-range tactics, the guerilla compaigns you may have been carrying on. Don't empty his bottles or lock up the liquor. Don't make a Federal case out of the dinner he didn't get home to. Don't excoriate him Sunday morning for what he doesn't remember doing at the party Saturday night.

Haggling over these symptoms will reinforce his rationalization that he is a much abused and misunderstood man.

PHASE II: THE SURROUND

1. Don't present a minority view

Don't underestimate the rationalization process. Nearly every alcoholic moves around the circle of his life busily patching up his battered self image. When that image is wounded by some new criticism of his ways, he tries to cut the critic out of his circle and hastens to cover the scar with a new tissue of rationalizations and "explanations".

Doctors who tell him he has liver damage and issue warning are not consulted again. Fellow workers who (without the backing of an enlightened company policy) suggest he better cut down a little are written off as prudes and busy-bodies. And the wife's harangues about the drinking go easily unheeded as long as they aren't echoed by any left who aren't drinking companions), and his other relatives, if they are the distant or tolerant kind.

Only rarely is the alibi structure brought down by a lucky shot or a glancing blow. Usually it takes a barrage.

Stop Covering Up: Efforts you have made to encourage others to think well of him, in spite of his drinking, have tended to support his rationalizations that he can handle his drinking, come what may. So stop protecting him from the effects of his drinking. Make no more apologies for his behavior, no further excuses on the days he can't make it to work. Stop covering his checks or meeting the obligations he doesn't want to face.

Enlist some help in setting up the surround. Presenting a majority view is not so much a question of lining up a lot of people as involving the right ones. Talk to the people who may be concerned about his drinking, whose opinions will count with him or whose attitudes can't be dismissed easily.

This might include other members of the family: the children, if they are old enough, brothers or sisters, his parents, perhaps yours. Maybe an old, close friend or two.

Don't risk the assumption that all these people will agree with you when the chips are down. Talk to them beforehand. They may not think the drinking results from an illness until you explain it to them.

Talk to his boss: His employer, or at least one of his working associates he respects, may be a vital ally. Some discretion must be used, of course, lest his job (if he still has one) be jeopardized needlessly. Whether it would be or not depends not only on the kind of work he does but also on how enlightened on this subject is the management of his firm.

As you weigh this question, don't think in terms of blowing the whistle on a drunk. Consider whether his employers ought to have an explanation of his behavior – that he suffers from an illness for which he needs treatment. Certainly they can expect him to be a more effective man once recovery begins than he has been recently. And it may be you'll find they are every bit as worried about his drinking as you are.

Count your advisors in: By this time you may have sought advice from both a doctor and a lawyer, to know what steps you should consider if recovery doesn't begin or continue once begun. Count these people in and quote the advice they gave you. (If they don't understand what you are trying to do or why, they may not know much about alcoholism, in which case their advice will be of questionable benefit.)

2. Set up the confrontation

You may want to make your presentation at a small family conference. But even if you decide to do it alone, make it clear that you have discussed the matter thoroughly with all the others and that they are in general agreement on what ought to be done.

Timing is crucial in two respects. First choose your time depending on his condition or what you might expect it to be. Don't try to discuss the matter when he's drunk. When he's still very sick the next morning, he may agree to anything (but not really mean it) simply because he is so acutely depressed he is willing to say or do anything to achieve even a temporary truce with you.

Secondly, don't begin your presentation until you have the time and the information needed

to complete it. If you try to tell the story in pieces, over several days, he may well have rationalized away and forgotten the first part by the time you bring up the later points.

Spell it all out, calmly, clearly, firmly but without rancor: 1) the diagnosis, fitted to his behavior, 2) the prognosis, if he continues without treatment: 3) the plan for recovery.

You are not bluffing or threatening, nor are you asking his permission. You are simply spelling out the facts of his present life, as well as they can be interpreted with recent, competent advice. You don't want to put him out of the house, or keep him away from the children or see him lose his job or sink deeper into debt. But you know – and he needs to know too – that unless he recovers from his illness, no one will be able to prevent these things from happening.

3. Offer hope

In what may well be his darkest hour in a long, long time, give him a good hope by expressing complete confidence in his ability to recover with the right kind of help. Insist that his life no longer need be the trial it has seemed to him lately. Assure him that thousands of people, including several you know, have recovered from this illness and that he will not find the process either difficult or painful. Be prepared to put him in touch – immediately, if he wants – with people who can give him further reassurance either in their professional capacity or from their own experience.

4. Push in only one direction

Don't bargain or debate. The purpose of all this is to get him started on recovery. So don't bicker over anything else, like what he thinks of your mother or whether he should give up his bad companions, or your effort may get sidetracked altogether, leaving you on the defensive. Don't settle for just swearing off, or changing drinking patterns.

Don't relent. As you plan your approach, and even as you apply the plan, you may feel more than once that you are betraying him or treating him with unjust cruelty. The opposite is true. You can't afford to relent, for his sake, until the alibi structure is penetrated and he becomes willing to accept help.

Set deadlines with care. Once you draw a line or set a condition, you will have to stick to it or the whole cause may be lost. So it would be unwise to hem him in too closely. Give him a few days – but no more – to decide what he is going to do. And allow him some choice in treatment methods, provided you can be sure they are adequate to meet the particular needs of his illness.

PHASE III: THE FOLLOW THROUGH

1. When he agrees to accept help

Follow the plan for recovery. Put him in touch with the appropriate sources of help, then give him a chance to make use of them. Don't crowd him too closely or lead.

It is essential that he take some initiative for his own recovery, however hesitant or unwilling this might seem the first few days.

As his recovery progresses, you may find that several adjustments in your family's habits are in order in a fairly short time – almost as many, perhaps, as were caused over several years by the progress of his illness. To guide your role in this process of recovery, three general suggestions will be helpful:

Forget the past. Don't taunt him or remind him needlessly of the sins of his past life, for this will only increase his feelings of guilt. And guilt, at this point, can serve no constructive purpose but can constitute a very real threat to the early stages of recovery. Neither you nor he nor anyone else can do anything to change the past anyway.

Live the present, as he will be learning to do as a necessary part of recovery. Take each day as it comes, leaving tomorrow for tomorrow. Forget those of yesterday.

Credit the future, no matter how often you may have been disappointed before. In recovery from a chronic emotional illness, hope is a fragile but vital link. Don't weaken it by dire warnings or kill it with skeptical doubt.

2. If he still refuses treatment

You must accept the prognosis yourself and begin to apply the appropriate course of action. You can't help a sick man by deciding that he isn't sick; wishing won't make him well. And if you back away from the facts you have presented, he will conclude, in perverse triumph, that he and his rationalizations were right all along.

If he doesn't respond right away, or if he makes only a gesture at accepting help, it will be because he doesn't believe you. It will mean that he hasn't accepted the fact of his condition.

He may respond a little later, when the prognosis you have given him begins to come true, especially if he sees that you are adjusting your own life on the assumption that, without help, he will probably get much worse.

In the meanwhile, go back to your advisors and review with them what you have done. No case of alcoholism becomes hopeless until those who would help the alcoholic don't want to try any more. And even if there are no more promising approaches to be tried, then you will at least have helped in facing some decisions on your own future which ought not be delayed.

Written by: R. Michael Swift, Executive Director
Fairfield County Council on Alcoholism, Inc.
Westport, Connecticut

TECHNIQUES OF INTERVENTION

What do we mean, INTERVENTION?

Intervention is a process in which a person is brought to the recognition that his use of beverage alcohol is abnormal, is alcoholic, is progressively self-destructive and must be terminated.

Intervention is the process in which the alibi structure or the drinker's system of rationalization relative to his drinking is broken down or destroyed.

Intervention is accomplished by a manipulation of the environment of the alcoholic so that he is no longer protected from the consequences of his drinking behavior, he is fully exposed and must pay the price of his own behavior.

Intervention can only be accomplished by a change in the attitude of those closest to the alcoholic . . . either in the family setting or in the working world where the consequences of the pathological drinking are first apparent and have the greatest impact.

Intervention is a dynamic process which is most easily accomplished the earlier it is used. As the condition progresses, the realities of intervention become more difficult, the choices more dramatic, the cost of failure higher.

Intervention is the process of forcing a person to a point of decision, forcing the person to choose between continued drinking or the loss of some important aspect of life.

Intervention to be successful must be deliberate, skillful, free of malice, consistent and uncompromising.

THE ASSUMPTIONS OF INTERVENTION

1. That all men are created with certain inalienable rights . . . and responsibilities.

2. Alcoholism, if permitted to run its full course, is 100% fatal.

3. Alcoholism, if permitted to run its full course, will destroy the drinker, destroy the marriage, and seriously affect the welfare and well-being of every member of the family.

4. The drinker is unable or unwilling to recognize he is involved and responsible for this destructive pattern.

5. He cannot or will not voluntarily give up the drinking.

6. He can and will give up the drinking (in most cases) if the pressure is great enough or the cost of continued drinking made high enough.

7. The result of intervention may be a choice on the part of the drinker to continue drinking.

8. Intervention is as important for the future well-being of the "family" as it is for the drinker.

9. The success of the intervention is not limited to the effect it has on the drinker. The family members can be saved in spite of the drinker.

10. In every case of alcoholism, there are always opportunities for a meaningful intervention. The important considerations are understanding the problem, selecting the right time, a first stand – no compromise, appropriate follow-through.

CAUTION – DANGER AHEAD

Interventions do occur; however, too frequently they are the result of a series of episodes which culminate in action that is punitive, motivated by fear, hurt, anger, disgust, hopelessness and helplessness. In the setting, they generally contribute to continued destruction of all involved. They leave in their wake deep resentment, guilt, anxiety, fear and frustration. Intervention can and should be purposeful, intelligent, with positive benefits and attitudes. It is in the truest sense an act of love and compassion.

ON CREATING A CRISIS

One of the most effective devices for arousing discussion in professional groups is to declare that "creating a crisis" in the life of an alcoholic may be an essential step in treatment. Among many practitioners in the so-called helping professions, it is almost an article of faith that the job of the therapist is to quiet the fears and anxieties of clients. If this procedure is followed with alcoholics, however, it may only mean the postponement of much needed help.

It is generally agreed that most alcoholics will seek help only when they hit bottom. For a long time, it was assumed that bottom had to be a skid row flea bag or a cell in the county jail but we are gradually recognizing the fallacy of that concept. Certainly, only a small fraction of the alcoholic population – possibly not more than 5 per cent – ever reaches skid row.

The bottom is different for each individual. It is that point at which he says to himself: "I've had it. If this is what alcohol does to me, I'd better quit drinking."

One of our patients, for example, hit bottom when he realized that his teen-age daughter was not inviting her friends to the home, because she was ashamed to let them see her father stretched out drunk on the living room couch. Another man hit bottom when he became aware of the fact his son refused paternal invitations to football games because of the inevitable bottle and the embarrassing antics that followed too much guzzling.

Unfortunately, most alcoholics do not reach bottom quite so early or at such relatively "respectable" levels. While the loss of one job may provide the impact for some, it may require the loss of ten or twenty jobs or a slide to the relief rolls for others.

One patient, whose drinking was limited to widely spaced episodes, decided that he always got into trouble on these occasions and never at any other time. During a spree, he irresponsibly wrote checks to the order of almost anyone who asked. Girls in cheap saloons and proprietors of shady gambling joints were frequent beneficiaries of his unintentional charity. Sometimes he sobered up in time to notify the bank to stop payment but explanations were, of course, humiliating. He sought help before he suffered complete financial ruin.

The onset of blackouts and the terror that often accompanies the inability to recall where one has been or what he has done can be the bottom for some alcoholics. One patient went to his garage on the morning after a strenuous night. He was startled to find a parking ticket from a city fifty miles distant under the windshield wiper of his car. He did not recall driving to or from the city, although a friend later confirmed the fact that he had made the trip. That was enough. He made an appointment at the Center on Alcoholism that afternoon.

Another patient, a successful sales manager, downed three martinis at lunch and returned to the office where he spent the afternoon dictating letters. During the next morning, he began to dictate the same correspondence again. When his secretary pointed out the duplication – with documentary evidence – he realized that the afternoon the previous day had been a complete balckout. At first he dismissed the experience as a freak accident but after several repetitions he decided to obtain help.

The phrase "hitting bottom" is, of course, another way of saying that the alcoholic finally meets the crisis that makes him want to alter his behavior. This may not be pleasant for him but at some level it is apparently necessary. If that is true, it seems to follow logically that the

sooner it happens the better. That is why it is so important for those in contact with alcoholics to help it happen if they possibly can.

A wife or mother may try to protect the alcoholic from such a crisis with the best intentions but her efforts are usually misguided. The alcoholic who is sheltered from the reality of his behavior has little reason to stop drinking. He continues to derive satisfaction (no matter how unhealthy) from his drinking and he does not have to face the consequences so why should he stop. The well-meaning spouse who calls the boss regularly to say her husband has a severe cold or an upset stomach (common euphemisms for hangover) is only permitting a progressive illness to get worse.

One young women, typical of many, purchased liquor for her husband because each time it happened he promised it would be the last. But, he pleaded, he could never endure this final weekend without a few drinks to subdue the shakes. The promise was repeated 52 times annually and as long as his devoted mate played the game his way there could be little genuine motivation to change.

A suburban couple had a 26-year-old son who drank himself into a stupor every Saturday night and was invariably found in an alley by the police who arrested him. Just as invariably his father, fearing community gossip, arranged his release after extracting a solemn vow that it would never happen again. But it always did. One night the youth tangled in a drunken brawl. This episode could not be concealed. Action became imperative and, luckily, culminated in successful treatment. It is possible, however, that some of the difficulties might have been avoided if a crisis had been forced sooner.

Much of the work with the families of alcoholics involves the effort to support them in trying to compel the alcoholic to face the consequences of his behavior. This is not easy. There is always a calculated risk for these people because it is impossible to predict with certainty which crisis will provide the stimulus for a change. Sometimes nothing does. But if wives, parents or relatives want to help effectively, they almost always have to take some positive action.

Sometimes the action has to be drastic; sometimes it doesn't. In any case, many who could help are reluctant to take the necessary steps because this may appear to be a betrayal or desertion of a sick person at the time of greatest trouble. Nevertheless, action that may seem harsh at the moment may well prove to be the most constructive in the long run.

We are fully aware, of course, that such action is not always possible. A mother with four children may choose to cling to her alcoholic husband, no matter how miserable the circumstances, because of the terrifying uncertainties of separation, even though that might precipitate a health crisis. If she does, she may have to wait for another type of crisis to arise – some bottom other than the loss of his family.

The choices for the non-alcoholic members of the family are often difficult. Sometimes they appear to be impossible. We do not know of any magic that can be performed. Coping with an alcoholic is always difficult. But experience has taught us that the alcoholic will seek help only when he hits bottom and that it can be helpful to raise that bottom to break his fall as soon as possible.

Cleveland Center on Alcoholism
Author: Herman E. Krimmel

Student Evaluation of the Chemical Dependency Curriculum

1. Do you know more about the disease of alcoholism now than you did before this unit?

2. Do you find it easier to think of an alcoholic as a person needing help, or do you still think of an alcoholic as a "drunk"?

3. What was the most interesting part of this unit?

4. Was this unit worthwhile? Why or why not?

5. What was the least interesting part of this unit?

6. What further information about drugs or alcohol do you need to help you understand their effects?

7. Comments.

TEACHER'S EVALUATION OF CHEMICAL DEPENDENCY UNIT

1. Please comment on the subject matter of this unit.

2. Do you feel this information is useful to the students?

3. Did you feel adequately prepared to teach the unit?

4. How did the students react to this unit? Bored, angry, interested etc.

5. Do you have any suggestions for a better approach to this topic? If so, please indicate.

6. Please comment on the lesson plans (Teacher Guides). Helpful, confusing, too detailed, etc.

7. Was it a problem for all of the World Studies teachers to use this curriculum at the same time?

8. Do you have any suggestions for better organizing the material?

9. What specific activities worked well for you? Did not work for you?

10. What is your overall evaluation of the curriculum? Please circle and then explain.

    Very Good Good Poor

11. Comments, suggestions for improvement.

CHEMICAL DEPENDENCY UNIT

PART IV

Additional Resource Material

Part IV - Additional Resource Material

Contents

Additional Films . . . . . IV, 1
Additional Activities . . . . . IV, 2
Projects . . . . . IV, 3
Speakers' List . . . . . IV, 4
Map to Bryan High . . . . . IV, 5
Speakers' Guidelines . . . . . IV, 6
Other Drug Information . . . . . IV, 7-16
Facts about the Effects of Alcohol . . . . . IV, 17-30
Alcoholism: Definition & Theories . . . . . IV, 31-36
Symptoms of Chemical Dependency . . . . . IV, 37-43
Counseling Recovering Alcoholics . . . . . IV, 44-55

OTHER FILMS AVAILABLE THROUGH O.P.S.

Permission has been given for you to use the following two films:

99 Bottles of Beer
Mamma Boozes, Baby Loses

The film titled "First Step" is available from our library.

Below is a list of other films dealing with alcoholism that our available in the Film Library.

1991	Conspiracy of Silence
1771	Thinking About Drinking
2242	Almost Everyone Does
2379	Alcohol, Tobacco & Drugs vs. Physical Fitness
2376	All Bottled Up
2064	America On the Rocks
2368	Boozers and Users
2338	First Step (scheduled for 12/9 - 12/16)

If you are interested in scheduling any of the above films, please call the Film Library - 554-6263.

ADDITIONAL ACTIVITIES

The following is a list of possible individual or group projects that could be used to supplement the learning activities found in this curriculum.

Easy Projects

1. Make a poster or collage using one of the topics below:
   a. Reasons people drink
   b. Alcoholism/chemical dependency
   c. Warning signs of alcoholism
   d. Physical effects of alcohol
   e. Kinds and types of alcoholic beverages
   f. History of alcohol
   g. Methods of advertising to promote drinking of alcohol

2. Collect cartoons or comic strips that deal with alcohol use. Attach them in a notebook or on poster paper. Briefly comment on the cartoonist's view of alcohol.

3. Select a picture or drawing and write a story about how alcohol or another drug relates to the picture.

4. Choose a song whose lyrics involve school or other drugs' use, then make a report (oral, written) discussing the attitudes toward alcohol or another drug expressed in the song.

5. Complete the following statements. Explain your reasons:
   a. If I could make my parents understand one thing about alcohol, it would be _____
   _____
   b. One thing about alcohol that really bugs me is _____

Advanced Projects

1. Develop a report on one of the following topics:
   a. Reasons why people drink or why people take drugs
   b. Drinking and Driving
   c. Teenage drinking
   d. Children of alcoholic parents
   e. Alateen
   f. Effects of alcohol, effects of another drug
   g. Local resources to help those people with alcohol and other drug problems

Reports can be written or oral or you may want to use slides and/or an audio tape to illustrate your points.

PROJECTS

1. Visit and prepare a report on AA, Alanon, Alateen, Treatment Center, Alcoholism/Chemical Dependency Counseling, etc.

2. Prepare a report on the messages of alcohol advertisements. An art presentation regarding these messages would include examples of ads mounted or assembled in a collage.

3. Research and write a report on any of these topics:
   (a) The Disease Concept of Alcoholism/Chemical Dependency
   (b) How the Family is Affected by Chemical Dependency
   (c) Teenage Drinking or Teenage Drug Use and Abuse
   (d) Drinking and Driving or other Drug Use and Affect on Driving
   (e) Teenage Chemical Dependency
   (f) How Any One Drug Affects the User
   (g) How Alcohol Affects Us Psychologically
   (h) How Alcohol Affects Us Physiologically
   (i) The Laws Regarding Drinking
   (j) The Laws Regarding Other Drugs
   (k) The Impact of Alcoholism on Society
   (l) The Impact of Drug Abuse on Society
   (m) Fetal Alcohol Syndrome

SPEAKER LIST

Alcoholism Information, Disease Concept, Family Informaion

Jean Kelley	O.A.C.A.	345-4080
Terry Rohren	United Catholic Social Service	558-3533
Scott Adams	U.C.S.S.	558-3533
Jane Berger	Eppley C.D.U., Adolescent Unit	397-3150
Doris Coppersmith	Immanuel	572-2016
Ann Haines	Immanuel	572-2016
Helga Smith	Immanuel	572-2016
Dick Sargeant	S. O. Coun. on Alcoholism	734-3000
Fr. Schwertley	U.C.S.S.	558-3533
Ed Sayers	N. O. Coun. on Alcoholism	453-5655

Legal Aspects

Steve Sturek	Sarpy Co. Diversion Prog.	339-2016
Frank Casserly	Alcohol Intake Action	558-3533

Intervention and Treatment Information

Betty Crawford	O.A.C.A.	345-5080
Hal Gillaspie, Jane Berger	Epply	397-3150
Ann Haines	Immanuel	572-2016

Other speakers could include those noted in the first group!

Medical Aspects of Alcoholism

Dr. Calvin Davis	U.N.M.C.	541-4804
Dr. Mulry	Mercy Hospital, Council Bluffs	328-1801

Recovering Chemically Dependent Persons

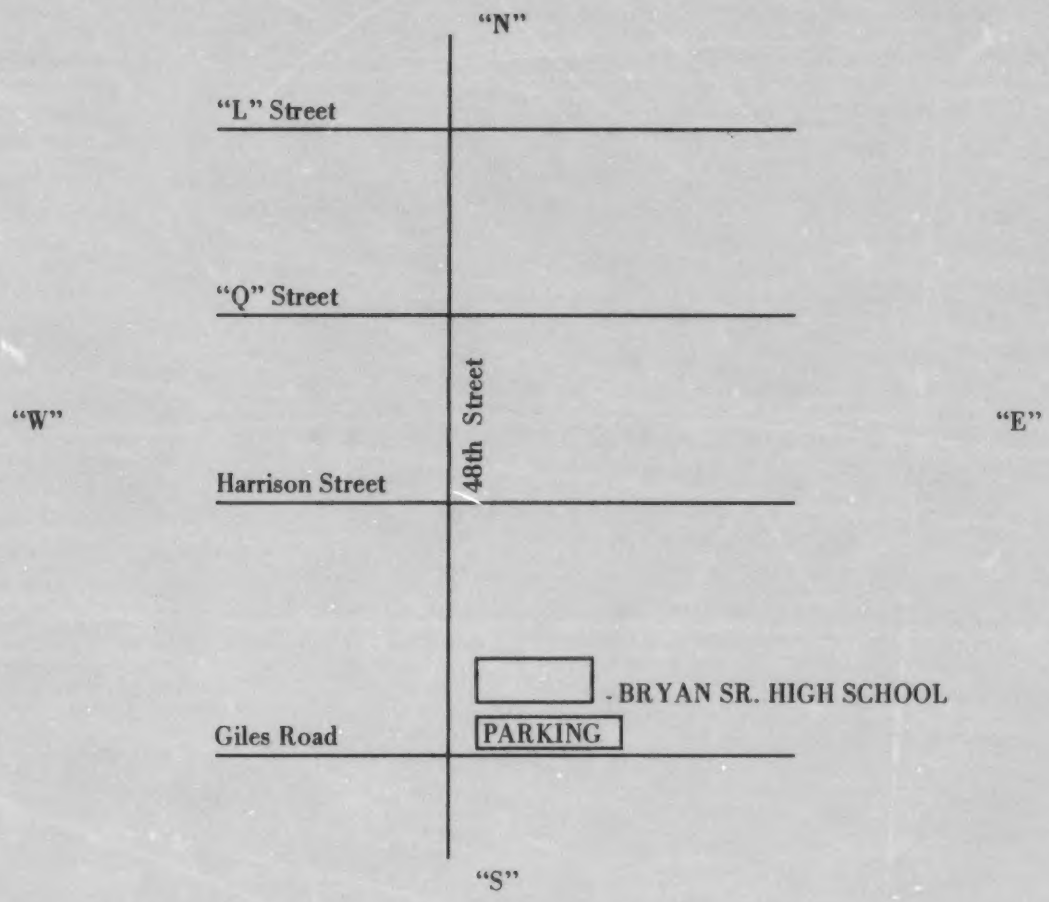
Steve W.	22 year old	551-3210
Ann C.	19 year old	731-2034
Chery S.	19 year old	397-3588
Gary N.	17 year old	397-3150 Ext. 503
Jim E.	19 year old	397-3159 Ext. 503
Mark D.	20 year old	558-3626
Tina P.	17 year old	292-1839
Kathy C.	22 year old	291-3905
Augie A.	40's Father of teenager recovering C.D.	348-4191 or 348-5006
Ray or (wife)	Excellent speakers!	
Chubby P.	Family of recovering C.D.'s	346-2913
Bob H., Sr.	40's	571-6853

AlAnon and AlAteen

Rosemary F.	(has teenagers, exp. speaker)	345-4080
Leslie	(leads AlAteen groups and experienced speaker)	330-2209

MAP TO BRYAN HIGH

Enter the southwest door from the parking lot. Walk down the hall to center of building (large conversation pit). Turn to center of building and the Guidance Office is the first door on the right.



SPEAKERS' GUIDELINES

(A copy should be sent to each speaker.)

1. Classwork has concentrated on alcoholism as a disease that has symptoms that are progressive. Alcoholism is able to be diagnosed and treated. Also, emphasize that alcoholism is a family disease that affects others in the family.

2. Jelnick's chart – symptoms of addiction and recovery.

3. Address the emotional symptoms as well as the physical symptoms.

4. Explain how other drugs also caused problems.

5. How did your chemical dependency affect your family and friends? Jobs? School and education?

6. What caused you to stop drinking/using?

7. As a family member, how were you affected by chemical dependency?

8. Try to avoid excessive "war stories." Kids tend to glamorize them and react by saying, "I was never that bad."

9. Do not overly emphasize God or the spiritual side of the program.

"OTHER DRUG INFORMATTION"

Note to Teachers

Care to be taken not to be moralistic.

Take advantage of lack of information and conflicting information to encourage students to research more.

All this information and research is subject to updating and not to be taken as absolute.

Again, reference to the fact that the "Other Drug" information is for student review and not felt to be appropriate as an in-class heavy subject emphasis. There is author concern that too much information causes student interest and past studies have indicated that curricular emphasis on other drug technicalities has raised the use of recreational drugs. We wish not to encourage drug experimentation or use.

MARIJUANA: WHAT IT IS AND WHAT IT DOES

What Exactly Is Marijuana?

Marijuana (also called pot, grass, reefer, or weed) comes from a plant, with the botanical name of Cannabis sativa, that grows wild and is cultivated in many parts of the world. Containing over 400 chemicals, this plant has the ability to intoxicate its users, primarily because of the psychoactive or mind-altering ingredient called delta-9-tetrahydrocannabinol, or THC. It is the THC content, found at various concentrations in different parts of the plant, which determines the potency. And the THC content is controlled by plant strain, climate, soil conditions, and harvesting.

Typically, the marijuana used in cigarettes (joints) is made from dried particles of the whole plant except the main stem and roots. In 1975, the average confiscated sample of marijuana contained 0.4 percent THC; in 1979, the average THC content was about 4 percent—a tenfold increase. Sinsemilla, a cultivated form of marijuana which is becoming more frequently available in this country, may contain as much as 7 percent THC.

Hashish (hash) is a green, dark brown, or black resin extracted from the Cannabis sativa plant and smoked to produce a high. In the past, hashish, which averages about 2 percent THC, contained more THC than marijuana. However, with the increased potency of marijuana on the streets, it now frequently is stronger than hashish.

Hash oil is an extract of the Cannabis sativa plant. It may contain up to 30 percent THC, many times the amount found in marijuana. Hash oil is a tarlike substance usually smoked in small amounts on tobacco or marijuana cigarettes or in small glass pipes.

How Do People Feel When They Smoke Marijuana?

Feelings of euphoria and relaxation are commonly reported as the result of smoking moderate amounts of marijuana. Physically, users experience an increase in heart and pulse rate, a reddening of the eyes, a dryness in the mouth and throat, a mild decrease in body temperature, and, on occasion, a sudden appetite. High doses may result in image distortions and hallucinations.

Many users claim that marijuana enhances their hearing, vision, and skin sensitivity, but these reports have not been confirmed by researchers. Studies of marijuana's mental effects have shown that the drug temporarily impairs short-term memory, alters the sense of time, and reduces the ability to perform tasks requiring concentration, swift reactions, and coordination.

Do People Ever React Badly to Marijuana?

Yes. The most common adverse reaction to marijuana is a state of anxiety, sometimes accompanied by paranoid thoughts; these can range from general suspicion to fear of losing control and going crazy. Acute anxiety reactions are usually experienced by novice users, and the symptoms generally disappear in a few hours as the drug's effects wear off. While anxiety reactions can usually be quieted by simple reassurance, some marijuana users may need professional help. Over 11,000 emergency room visits relating to marijuana use were reported in 1979.

Can Marijuana Cause Mental or Psychological Problems?

Marijuana does not directly cause mental problems, but like many other drugs, it appears to bring to the surface emotional problems and can even trigger more severe disorders, particularly schizophrenia. People suffering from depression or other emotional disturbances who use marijuana to treat symptoms often cause a worsening of the problem. An estimated 5,000 people seek professional treatment every month for problems related to marijuana.

How Can Marijuana Affect Your Child?

In addition to the physical effects described later, a very real danger in marijuana use is its possible interference with growing up. As research shows, the effects of marijuana can interfere with learning by impairing thinking, reading comprehension, and verbal and arithmetic skills.

Scientists also believe that the drug may interfere with the development of adequate social skills and may encourage a kind of psychological escapism. Young people need to learn how to make decisions, to handle success, to cope with failure, and to form their own beliefs and values. By providing an escape from "growing pains," drugs can prevent young people from learning to become mature, independent, and responsible.

How Much Is Heavy Marijuana Use?

For the purposes of this booklet, heavy use is defined as smoking at least once a day. However, many young people when asked to define heavy use say that it means smoking three or more times a day.

What Is Marijuana "Burn Out"?

"Burn out" is a term first used by marijuana smokers themselves to describe the effect of prolonged use. Young people who smoke marijuana heavily over long periods of time can become dull, slow moving, and inattentive. These burned-out users, also referred to as "vegged out" or "space cadets," are sometimes so unaware of their surroundings that they do not respond when friends speak to them. Such youngsters, however, do not consider themselves to be burned out. Scientists believe that burn out may be a sign of drug-related mental impairment that may not be completely reversible, or is reversible only after months of abstinence.

Can Marijuana Cause Addiction?

While increasing numbers of people are reporting problems associated with their marijuana use, and many are having problems stopping after heavy or long-term use, there is little evidence that the drug is physically addicting. Animal studies have shown, however, that a tolerance to THC can develop. This means more and more marijuana must be used over time to achieve the high once experienced by using smaller amounts.

Does Marijuana Lead to the Use of Other Drugs?

There is nothing in marijuana itself that causes people to use other drugs. While studies have

shown that the use of tobacco and alcohol often precedes marijuana use, the overwhelming majority of marijuana smokers do not go on to use other drugs. But some do; surveys show that the earlier marijuana use begins, the more likely it is that the use will be heavy. Early use also increases the likelihood of subsequent experimentations with other drugs such as hashish, hallucinogens, cocaine, amphetamines, and occasionally barbiturates and heroin.

How Are People Introduced to Marijuana?

Most people are introduced to marijuana by their peers—that is, by people their own age, usually acquaintances or friends. Pushers are rarely involved when a person first smokes marijuana.

How Many People Smoke Marijuana?

Over 50 million Americans have tried marijuana at least once. Approximately 22 million were considered current users at the time of the last national survey in 1979—"current" because they reported smoking marijuana during the month preceding the survey.

A breakdown of [illegible]

60 percent of [illegible] of nine was a daily user;

8 percent of the 12 to 13 [illegible] smoked marijuana at least once, and half of this group was [illegible]

32 percent of the 14 to 15 [illegible] and 17 percent were still using it.

While children under the age of 12 [illegible] any in the 12 to 13 age group report that they first tried marijuana, and even started smoking it regularly, while they were still in grade school—and probably before their parents even suspected they knew about the drug.

Is Drug Paraphernalia Legal?

The sale of most drug paraphernalia is legal in many States. However, a number of States and local communities, often at the request of parent groups, have banned the sale of paraphernalia to minors or have restricted its sale to specified parts of town—away from schools, for example. Other jurisdictions have outlawed the selling of drug equipment altogether. In addition, the Federal Government has developed a model State law to ban drug paraphernalia.

What Is Meant by Decriminalization?

Decriminalization refers to the process of reducing the penalty, which in some States is imprisonment, for possession of small amounts of marijuana. Many feel that, while marijuana use should be discouraged, imprisonment is too harsh a penalty, especially for young users. Many States have already changed their laws, making possession of small amounts for personal use a misdemeanor and requiring civil fines, mandatory drug education programs, or involvement in public service projects instead of prison.

Laws remain harsh for dealers of marijuana. As punishment for personal possession decreases, punishment for selling marijuana has increased in many States.

Isn't Decriminalization Just One Step Away From Legalization?

No. Because decriminalization continues to provide penalities, it still conveys the message that using marijuana is illegal. The word "decriminalization," so often misunderstood, does not mean marijuana is "safe" or "okay" to use. Nor does it mean that legalization is just around the corner. It merely refers to establishing a more appropriate punishment for the offense of possessing small amounts of marijuana for personal use. Possession of large amounts—usually more than 1 ounce—remains a felony in all States.

What Happens if You Drive After Smoking Marijuana?

Marijuana delays a person's response to sights and sounds—so that it takes a driver longer to react to a dangerous situation. The ability to perform sequential tasks can also be affected by smoking marijuana. As a result, a marijuana smoker's biggest driving problems occur when faced with unexpected events, such as a car approaching from a side street or a child running out from between parked cars. The greater the demands of a driving situation, the less able the marijuana user will be to cope. The driver who doesn't feel high may still be under the influence of marijuana since its effects may last for several hours after the high has passed.

The combined use of marijuana and alcohol is more hazardous than the use of either alone. But combined use is becoming widespread; one researcher reported that nearly half of regular marijuana users combine alcohol with marijuana use. Surveys have indicated that from 60 to 80 percent of marijuana users sometimes drive while high.

Marijuana's Effects on the Body

Most of the information on marijuana's effects on the body has been established through studies on both humans and animals, some only by research on animals. Stringent U.S. drug-testing laws require that most research be conducted on men over 18; very few studies have involved women, and none have used adolescents.

Marijuana research is relatively new by scientific standards. Many more years and additional studies will be needed before the long-term effects of marijuana use are fully known.

How Long Does Marijuana Stay in the Body After It Is Smoked?

When marijuana is smoked, THC, its active ingredient, is absorbed by many tissues and organs in the body. The body, in its attempt to rid itself of the foreign chemical, chemically transforms the THC into metabolites. Human tests on blood and urine can detect THC metabolites up to a week after marijuana is smoked. Tests involving radioactively labeled THC have traced these metabolites in animals for up to a month.

Can Marijuana Cause Brain Damage?

To date, no definite neurological study of humans has turned up evidence of marijuana-related permanent brain damage. However, in a recent study of rhesus monkeys, the animals were trained to smoke a marijuana cigarette 5 days a week for 6 months. The researcher reported that persistent changes in the structure of the monkeys' brain cells followed.

This and other studies have led researchers to conclude that the possibility of subtle and lasting changes in brain function from heavy and continuous marijuana use cannot be ruled out.

How Does Marijuana Affect the Heart?

Marijuana use increases the heart rate as much as 50 percent and can bring on chest pain in people already experiencing a poor blood supply to the heart. For this reason, doctors believe that people with heart conditions, or those who are at high risk for heart ailments, should not use marijuana.

How Does Marijuana Affect the Lungs?

Scientists believe that marijuana can be particularly harmful to the lungs because some users inhale the unfiltered smoke deeply and hold it in their lungs as long as possible, thereby keeping the smoke in contact with lung tissue for prolonged periods. Repeated inhalation of smoke, whether marijuana or tobacco, inflames the lungs and affects pulmonary functions. In one study on humans, it was found that smoking five joints a week over time is more irritating to the air passages and impairs the lungs' ability to exhale air than smoking almost six packs of cigarettes a week. Another study on animals using THC levels similar to daily human use found that extensive lung inflammation developed after 3 months to a year of use.

Can Marijuana Cause Cancer?

While marijuana smoke has been found to contain more cancer-causing agents than tobacco smoke, there is no direct evidence so far that marijuana can cause cancer in humans. However, biopsies of human lung tissue chronically exposed to marijuana smoke in a laboratory showed cellular changes called metaplasia that are considered precancerous. In laboratory tests, the tars from marijuana smoke have produced tumors when applied to animal skin.

Does Marijuana Affect the Body's Ability To Fight Infection?

This question remains unresolved. Some reports suggest that white cell information central to the body's immune response is affected by heavy marijuana smoking. Some laboratory animal studies have found that the immune response is significantly suppressed in mice and rats subjected to high doses of marijuana. Other studies have not confirmed these findings. Because the immune response is so important to good health, long-term studies are essential to determine if marijuana users become more susceptible to disease.

How Does Marijuana Affect the Hormonal and Reproductive Systems?

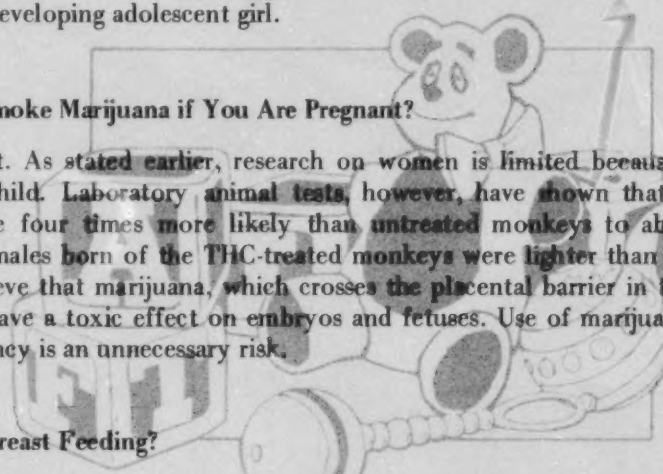
MEN

A few studies of adult males have found that chronic marijuana users had lower levels of testosterone (the principal male sex hormone) than nonusers, and that abstention from marijuana after heavy use produced a reversal of this condition. Other research has shown that the sperm count in young adult males diminishes as marijuana use increases. Still other studies have shown that some of the sperm of chronic marijuana users are defective and nonfunctional. On the basis of these findings, scientists feel that those with marginal fertility

or endocrine functioning should avoid marijuana. In addition, marijuana has been shown to affect the growth hormone from the pituitary. These findings indicate that marijuana may be particularly harmful during adolescence, a period of rapid physical and sexual development.

WOMEN

Information about the reproductive effects of marijuana on women is scarce; marijuana research on women of childbearing age is not permitted because of possible reproductive risks. But one recent study of marijuana use and human female endocrine functioning with 26 women using street marijuana of 6 months or more found they had defective menstrual cycles three times more frequently than a similar group of nonusers. These defective cycles involved either a failure to ovulate or a shortened period of fertility—findings which suggest that regular marijuana use may reduce fertility in women. Many female animal studies have been completed and show that marijuana influences levels of estrogen, the principal female sex hormone, and progesterone, another reproductive hormone, as well as the growth hormone from the pituitary. These studies suggest that heavy use should be avoided by the physically and sexually developing adolescent girl.



Is It OK To Smoke Marijuana if You Are Pregnant?

Definitely not. As stated earlier, research on women is limited because of possible risks to the unborn child. Laboratory animal tests, however, have shown that THC-treated female monkeys were four times more likely than untreated monkeys to abort or have stillborn infants. And males born of the THC-treated monkeys were lighter than usual in birth weight. Scientists believe that marijuana, which crosses the placental barrier in the pregnant mother's womb, may have a toxic effect on embryos and fetuses. Use of marijuana or any other drug during pregnancy is an unnecessary risk.

What About Breast Feeding?

Animal studies have shown that THC from marijuana can be transmitted to a baby through the mother's milk and that traces of THC have been found in the baby's urine and feces after nursing. Scientists have no doubt that THC is also transmitted in human milk, but because of possible risks to the mother and child, human research has not been done.

Marijuana Jargon

Parents today are trying to cope not only with marijuana but also with the drug's vocabulary. While drug terms are continually changing and are often different in various parts of the country, this list may help you decipher the most popular marijuana jargon.

Acapulco Gold – a potent strain of marijuana with gold or yellow highlights.

Bong – a cylindrical water pipe used to smoke marijuana.

Burn out – a slang term for a state of apathy and deadened perceptions which can result from habitual use of marijuana.

Buzz – slang term for a high or a drug-induced euphoria.

Colombian – a potent strain of marijuana.

Decriminalization – process of reducing penalities for personal use of marijuana from prison sentences to civil fines.

Dime – a quantity of drugs which sells on the streets for $10.

Dope– slang term for marijuana and other drugs.

Duster – cigarette made of tobacco, mint leaves, marijuana, parsley sprinkled with phencyclidine (PCP), also known as Angel Dust.

Ganja – a potent form of Cannabis obtained from the flowering tops and leaves of the plant. It may also be used to refer to marijuana in general.

Grass – slang term for marijuana.

Hashish – a form of Cannabis made either from the Cannabis sativa plant or its resin.

Hash oil – a form of Cannabis which is extracted or distilled from the Cannabis sativa plant.

Head shops – stores which specialize in the sale of drug paraphernalia and drug-related items.

High – a widely used slang term for euphoria and intoxication.

Hit – a single drag of inhalation of marijuana smoke.

Joint – a hand-rolled marijuana cigarette.

Killer weed – slang term for PCP-treated parsley or marijuana.

Loaded – slang term for state of being high or intoxicated.

Nickel – a quantity of marijuana which sells on the street for $5.

Ounce – a standard unit of measurement for marijuana.

Paraphernalia – drug equipment or gadgets usually sold in head shops.

Pot – slang term for marijuana.

Reefer – slang term for marijuana.

Roach – the small end of a marijuana joint which remains after most of the cigarette is smoked.

Roach clip – a device used to hold the roach or the tail end of a marijuana joint.

Rolling papers – cigarette papers used to make a marijuana joint.

Scales – paraphernalia used to weigh drug quantities for selling purposes.

Smoking stones – paraphernalia used to hold marijuana joints while smoking.

Space cadet – slang term for a habitual marijuana user whose senses have become dulled.

Spaced out – slang term for a drug-induced state of being lost or out of touch with surroundings.

Stash – Any container or place used to store marijuana or other drugs.

Stoned – slang term for being high or intoxicated from marijuana.

Supergrass – slang term for marijuana treated with phencyclidine (PCP or Angel Dust).

Toke – slang term for an inhalation of marijuana or hashish smoke.

Water pipe – paraphernalia used to smoke marijuana or hashish which filters the smoke through water.

Weed – slang term for marijuana.

Common Drugs and Abuse

CATEGORY	Drugs	Sample trade or other names	Medical uses	Dependence: Physical	Dependence: Psychological	Effects in hours	Possible effects	Effects of overdose	Withdrawal symptoms
CANNABIS	Marijuana	Pot, grass, reefer, sinsemilla	Under investigation	Unknown	Moderate	2-4	Euphoria, relaxed inhibitions, increase in heart and pulse rate, reddening of the eyes, increased appetite, disoriented behavior	Anxiety, paranoia, loss of concentration, slower movements, time distortion	Insomnia, hyperactivity, and decreased appetite occasionally reported
	Tetrahydrocannabinol	THC							
	Hashish	Hash	None						
	Hash oil	Hash oil							
DEPRESSANTS	Alcohol	Liquor, beer, wine	None	High	High	1-12	Slurred speech, disorientation, drunken behavior	Shallow respiration, cold and clammy skin, dilated pupils, weak and rapid pulse, coma, possible death	Anxiety, insomnia, tremors, delirium, convulsions, possible death
	Barbiturates	Secobarbital, Amobarbital, Butisol, Tuinal	Anesthetic, anti-convulsant, sedative, hypnotic	High-moderate	High-moderate	1-16			
	Methaqualone	Quaalude, Sopor, Parest	Sedative, hypnotic	High	High	4-8			
	Tranquilizers	Valium, Librium, Equanil, Miltown	Anti-anxiety, anti-convulsant, sedative	Moderate to low	Moderate				
STIMULANTS	Cocaine	Coke, flake, snow	Local anesthetic	Possible	High	½-2	Increased alertness, excitation, euphoria, increase in pulse rate and blood pressure, insomnia, loss of appetite	Agitation, increase in body temperature, hallucinations, convulsions, possible death, tremors	Apathy, long periods of sleep, irritability, depression
	Amphetamines	Biphetamine, Dexedrine	Hyperactivity narcolepsy			2-4			
	Nicotine	Tobacco, cigars, cigarettes	None	High	High				
	Caffeine	Coffee, tea, cola drinks, No-Doz		Low	Low			Agitation, increase in pulse rate and blood pressure, loss of appetite, insomnia	
HALLUCINOGENS	LSD	Acid	None	None	Degree unknown	8-12	Illusions and hallucinations, poor perception of time and distance	Drug effects becoming longer and more intense, psychosis	Withdrawal symptoms not reported
	Mescaline and peyote	Button, Cactus							
	Phencyclidine	PCP, angel dust	Veterinary anesthetic	Unknown	High	Variable			
	Psilocybin · psilocin	Mushrooms	None	None	Degree unknown	6			
INHALANTS	Nitrous oxide	Whippets, laughing gas	Anesthetic	Possible	Moderate	Up to ½ hr.	Excitement, euphoria, giddiness, loss of inhibitions, agressiveness, delusions, depression, drowsiness, headache, nausea	Loss of memory confusion, unsteady gait, erratic heart beat and pulse, possible death	Insomnia, decreased appetite, depression, irritability, headache
	Butyl nitrite	Locker room, rush	None						
	Amyl nitrite	Poppers, snappers	Heart stimulant						
	Chlorohydrocarbons	Aerosol paint, cleaning fluid	None						
	Hydrocarbons	Aerosol propellants gasoline, glue, paint thinner	None						
NARCOTICS	Opium	Paregoric	Antidiarrheal, pain relief	High	High	3-6	Euphoria, drowsiness, respiratory depression, constricted pupils, nausea	Slow and shallow breathing, clammy skin convulsions, coma, possible death	Watery eyes, runny nose, yawning, loss of appetite irritability, tremors, panic, chills and sweating, cramps, nausea
	Morphine	Morphine, Pectoral syrup	Pain relief, cough medicine						
	Codeine	Codeine, Empirin Compund with Codeine, Robitussin A-C		Moderate	Moderate				
	Heroin	Horse, smack	Under investigation	High	High	12-24			
	Methadone	Dolophine, Methadose	Heroin substitute, pain relief						

Pages IV, 8-15 taken from For Parents Only: What You Need to Know About Marijuana, U.S. Department of Health & Human Services.

FACTS

I. THE EFFECTS OF ALCOHOL

A. OVERVIEW

Current medical doctrines agree that whatever affects one organ may influence others, and that physical, mental, and emotional influences are interdependent. Any discussion of the physical effects of alcohol must, therefore, keep this interdependence in mind. The result being that the physical effects of the drug alcohol may be influenced by variables which are difficult to measure, at best. The atmosphere of a cocktail party, or that of skidrow, a mood of despair or of elation, may well influence alcohol's effects on the individual. With these important considerations, this chapter presents information about the effects of alcohol on the body's activities.

Any food or drug (and alcohol is both) taken into the digestive system is immersed in powerful chemicals and is tossed about by the muscular contractions of the stomach and intestines. Most foods, as a result of this process, are reduced to forms simple enough in molecular and chemical structure to be absorbed at once. Its molecules are small enough and its chemical pattern simple enough to be used for fuel almost immediately after swallowing.

The way alcohol is used and disposed of, its metabolism, consists of four phases:

1. Absorption, which takes place in the stomach and small intestine, where alcohol enters the bloodstream.
2. Distribution, in which alcohol travels in the blood to each organ, tissue, and cell. By simple diffusion alcohol leaves the bloodstream and enters the cells.
3. Oxidation, in which the chemical structure of alcohol is remodeled to release heat and energy. The heat and energy, or calories, resulting from the oxidation of alcohol are used by the body cells. Whereas most foods may be metabolized in any cell of the body, alcohol is metabolized chiefly in the cells of the liver.
4. Elimination, during which a small quantity (2 to 5 per cent) of the alcohol escapes unused via the breath, urine, or sweat glands.

Two of the phases of alcohol metabolism, absorption and oxidation, will be discussed more fully below because they are pertinent to the problems arising from misuse of alcohol. Ill effects from alcohol result when its oxidation lags far behind its absorption.

B. ABSORPTION

Absorption is the process whereby the tiniest of blood vessels, the capillaries, in the walls of the stomach and small intestines absorb alcohol very soon after it is swallowed and transport it through the body. Within a few moments after a sip or two is taken, some of it is detectable in the blood. Once it enters the bloodstream, the alcohol begins to affect the various organs including the brain. It is during the time lag between intake and use, or between absorption and oxidation, that alcohol's effects are experienced. There are numerous influences which may hasten or deter the absorption rate.

On the physical side, how fast people drink, their weight, whether they have recently

eaten, their drinking history, body chemistry, and the type of beverage and mixer used are all influential. On the psychological side, the drinking situation, the drinker's moods and attitudes, and their previous experience with alcohol are all contributing factors.

1. Speed of drinking. The more rapidly an alcoholic beverage is ingested, the higher will be the peak blood-alcohol concentrations. Thus, these levels are lower when the beverage is "nursed" or taken in divided amounts than when it is gulped or taken in a single dose.

2. Body weight. The greater the weight of the body muscle of an individual, the lower will be his/her blood-alcohol concentration resulting from a given amount of alcohol. For example, the blood-alcohol level produced in a 180-pound person drinking four ounces of distilled spirits will usually be substantially lower than that of a 130-pound person drinking the same amount in the same length of time—and the larger person will usually show fewer effects.

3. Presence of food in the stomach. Eating while drinking notably retards the absorption of alcohol, especially when alcohol is consumed in the form of distilled spirits or wine. When alcoholic beverages are taken along with a substantial meal, peak blood-alcohol concentrations may be reduced by as much as 50 percent.

4. Drinking history and body chemistry. Each individual has a personal pattern of physiological functioning. which may effect his/her reactions to alcohol. For example, under a number of conditions the stomach empties more rapidly than is normal, and alcohol seems to be absorbed more quickly. Emptying time may be either slowed or speeded by anger, fear, stress, nausea, and the condition of the stomach tissues. In individuals with a long history of drinking, tolerance to alcohol develops, so that an increased dosage must be used to give effects similar to those obtained with the original dose. Thus, a person with extensive drinking problems is likely to require far more alcohol to get "high" than an inexperienced drinker. In individuals with serious drinking problems, the curve of tolerance is reversed, and again they are responsive to relatively small amounts of alcohol.

5. Type of beverage. In all the major alcoholic beverages—beer, wines, cocktail or dessert wines, liqueurs or cordials, and distilled spirits—the chief ingredient is identical: ethyl alcohol. In addition, these beverages contain a variety of other chemical constituents. Some come from the original grains, grapes, and other fruits. Others are produced during the chemical process of fermentation or during distillation or storage. Still others may be added as flavoring or coloring. These nonalcoholic "congeners" contribute in their own right to the effects of certain beverages, either directly affecting the body, or affecting the rates at which alcohol is absorbed into the blood and is oxidized in the tissues.

   Beers, wines, and distilled spirits may vary markedly in the rate at which the alcohol they contain is absorbed into the blood. In general, the higher the concentration of the alcohol, the more rapid is its absorption, and the higher the concentration of "congeners," the slower is its absorption. The net result is that beer and wine have slower effects than when the same amount of alcohol is consumed in the form of liquor. However, any two drinks which contain the same amount of alcohol will eventually have the same effects. Diluting an alcoholic beverage with another liquid, such as water, also helps to slow down absorption, but mixing with carbonated beverages may increase the absorption rate.

C. OXIDATION

The speed of alcohol absorption generally affects that rate at which one becomes intoxicated: conversely, the speed of alcohol oxidation affects the rate at which one becomes sober again. Once absorbed into the blood-stream and distributed throughout the body, alcohol undergoes metabolic or oxidative changes. A major part of these processes occurs in the liver. Alcohol is changed first into acetaldehyde, a highly irritating, toxic chemical; however, this substance rarely accumulates, since it is changed quickly into acetate. Acetate (the same as that produced as an intermediate in sugar metabolism) is transformed into a variety of other compounds, and eventually is changed completely into carbon dioxide and water. The total metabolic process yields about seven calories of energy from each gram of alcohol. Almost all of the ingested alcohol is metabolized by the liver; however, from 2 to 3 per cent is excreted, chemically unchanged, mostly in urine, breath, and sweat.

1. The Rate of Oxidation may have a small influence on behavioral tolerance to alcohol, but there are no significant differences in the ability to oxidize alcohol between the alcoholic person and the nonalcoholic. Normal drinkers can metabolize on the average approximately 7 grams per hour of pure alcohol; 8 grams in the form of whiskey and 9 grams in the form of beer. As a general rule, it will take as many hours as the number of drinks consumed to sober up completely.

   Considerable effort has been devoted to a search for some method which could effectively speed the rate of alcohol metabolism, and thus provide rapid sobriety. Recent interest has been shown in administering fructose, a fruit sugar; however, neither this nor any other agent has yet been found to make any clinically significant difference in the rate of alcohol metabolism. The ideas of exercise, fresh air, cold showers, hot baths, shock or black coffee are still tried and may cause a person to feel more wide awake, but the fact remains that they have no effect on the oxidation rate. All one can do is wait, and let the liver do its work.

D. HANGOVER

A familiar aftereffect of overindulgence is the hangover—the morning-after misery of fatigue combined with nausea, upset stomach, anxiety, and headache. The hangover is common and unpleasant, but rarely dangerous. It affects the moderate drinker who occasionally drinks too much, as well as the excessive drinker after prolonged drinking. The exact mechanism is unknown. Symptoms are usually most severe many hours after the peak of drinking, when little or no alcohol can be detected in the body. Although the hangover has been blamed on mixing drinking, it can be produced by any alcoholic beverage alone, or by pure alcohol. There is inadequate evidence to support beliefs that it is caused by vitamin defiencies, dehydration, fusel oils (nonalcoholic components of alcoholic beverages which are relatively toxic, but present in clinically insignificant amounts), or any other nonalcoholic components.

No satisfactory specific treatment for hangover is known. There is no scientific evidence to support the curative claims of popular remedies such as coffee, raw egg, oysters, chili peppers, steak sauce, "alkalizers," vitamin preparations, "the hair of the dog," or such drugs as barbiturates, amphetamines or insulin. Doctors usually prescribe aspirin, bed rest, and solid food as soon as possible. Hangovers can be prevented by drinking slowly, with food in the stomach, under relaxed social circumstances, in quantities limited enough to avoid intoxication.

E. SHORT-TERM EFFECTS

Alcohol is a drug, every bit as active physiologically as many of the so-called "drugs" that are usually ingested as pills. Its primary effects are in the central nervous system although the whole body is affected.

Alcohol is often thought of as a stimulant, because it appears to make people more lively and uninhibited. Indeed, in very low concentrations, it does stimulate cellular activity in most organisms, from the simplest bacteria to the most complex mammals. And, in smaller quantities, alcoholic beverages slightly increase the heart rate, slightly dilate blood vessels in arms, legs, and skin, moderately lower blood pressure, stimulate appetite, increase production of gastric secretion, and markedly stimulate urine output. But as with most other biologically active chemicals, the general physiological effects of alcohol depend on the amount or concentration in the specific cells, tissues, or organs affected. In higher concentrations it can depress function, seriously injure or even kill cells.

Alcohol is technically considered to be a depressant, since it primarily depresses functions of the central nervous system. The reactions are related not necessarily to the amount of alcohol drunk, but to its concentration in the blood. When blood-alcohol levels are low, their effect is usually mild sedative, relaxation, or tranquility. At higher levels, at least in some people, there is a suggestion of stimulation of the brain; they become talkative, aggressive, and excessively active. However, these changes are thought to result from depression of the most highly developed brain centers which normally inhibit or restrain such behavior. At still higher levels, great depression of lower parts of the brain occurs, producing lack of coordination, confusion, disorientation, stupor, anesthesia, coma, or death. (See brain diagram on Page 28.)

F. LONG-TERM EFFECTS

Drinking alcohol in moderation apparently does the body little permanent harm. But when taken in large doses, over long periods of time, alcohol can prove disastrous, impairing both the quality and length of life. Structural damage to several major organs, such as the heart, brain, and liver may result.

1. Liver. The most common effect in the liver after alcohol intake, which may occur after intake of less than intoxicating amounts, is fatty liver—an accumulation of lipid or fat in varying portions of the liver cells. Fatty liver generally appears to have few functional effects and is reversible upon cessation of alcohol intake. However, recently a syndrome of sudden fatty-liver deaths has been described and it has been reported to be an important cause of sudden death in individuals between the ages of 25 and 44.

   Alcoholic hepatitis is usually considered more serious than fatty liver. It involves an inflammation of the liver and alteration in the structure and function of its cells. These events, which by themselves are significant, are generally considered to be precursors of the subsequent and most serious phase of alcoholic liver disease, cirrhosis.

   Although the continuity between chronic fatty liver, hepatitis and cirrhosis has long been suspected, the question of the progression of these injuries has never been resolved.

   Cirrhosis of the liver is a major cause of incapacitating illness and premature death in alcoholic persons. During cirrhosis the tissues of the liver change in form. Eventually

scarring occurs and the liver begins to harden. As this occurs, the liver loses its ability to carry out its functions necessary to human life. Mortality from cirrhosis has risen to the point that in some large urban areas cirrhosis represents the fourth largest cause of death between the ages of 25 and 45. Not all those affected with cirrhosis are alcoholic people, however, nor do all alcoholic persons develop cirrhosis. The exact relation between alcoholism and cirrhosis has thus remained something of a medical mystery and the subject of intense debate. In general, the concept has prevailed that excessive intake of alcohol by itself is not sufficient to produce cirrhosis and that other factors must play a key role.

Some investigators believe that the major factor in the causation of cirrhosis is dietary deficiency. It is important to note that a large proportion of alcoholics have serious vitamin and other nutritional deficiencies. Many scientists seem convinced that adequate nutrition provides an effective protection against cirrhosis. Some investigations, however, have shown that large amounts of alcohol may cause liver damage even in properly fed subjects.

2. Heart. Although the causes of various heart diseases are not yet fully understood, concern about the possible role of alcohol has been growing. However, there appear to be contradictory findings in two different phases of research on heart disease.

On the one hand, there is evidence that, unlike smoking or high blood pressure, alcohol is not a significant risk factor associated with heart attacks. Other studies of nonalcoholic populations have indicated that moderate alcohol use is actually associated with a lower risk of heart attack, raising the question whether small amounts of alcohol may play a slightly "protective" role against coronary heart disease.

On the other hand, recent clinical studies as well as experimental work on cardiomyopathy, a disease of the heart muscle rather than of the coronary blood vessels, have indicated that even moderate amounts of alcohol can stress tissue of the cardium or the main heart muscle. Numerous medical reports have verified the occurrence of fatalities due to cardiomyopathy in alcoholic persons, even where malnutrition, which formerly was a main cause of heart disease in alcoholic persons, was not involved.

Such contrasting findings complicate preventive health care policies as well as physicians' advice to patients regarding alcohol use. However, the possibility of alcohol having both beneficial and harmful effects is not necessarily a contradiction. Cardiomyopathy and coronary disease are two distinct types of heart disease, involving different parts of the cardiovascular system.

3. Gastrointestinal Tract. The effects of alcohol on other parts of the gastrointestinal tract have not been as intensively studied as those on the liver, but sufficient knowledge is available to indicate that chronic heavy drinking has a variety of injurious effects on the gastrointestinal system.

When strong alcoholic beverages are taken the irritating effect may cause direct local injury. The possible sites of such injury are the mouth, the stomach, and the esophagus. An increased frequency of cancer of these parts of the digestive tract has been reported among alcoholic persons.

Ingestion of alcoholic beverages stimulates acid production in the stomach, delays emptying of the stomach, and may damage mucous lining.

Maladies of the small intestine are not often a medical complication in alcoholism, but occasionally they are troublesome. Inability to absorb various substances, fat and vitamin B12 have been reported in alcoholic patients. The mechanism by which alcohol affects the small intestine is at present unknown. All the intestinal injuries associated with chronic alcohol abuse appear to be rapidly reversible.

Alcoholism is occasionally associated with pancreatitis and pancreatic insufficiency. Individuals with a long history of alcohol abuse show a diminished response to pancreatic stimulation. These abnormalities appear to be reversible when alcohol is discontinued, and may be the result of other gastrointestinal problems caused by drinking rather than alcohol itself.

4. Central Nervous System. Of all the physiological, metabolic and pharmacological effects of alcohol that have been discussed, the most common and most important is that alcohol causes intoxication. Incredible as it may seem, however, there is no generally accepted explanation of how alcohol induces intoxication. It has been commonly assumed that alcohol exerts its fundamental effect upon the brain by interacting in some as yet undefined way with the nerve cell membrane. The assumption that alcohol interacts perhaps in a nonspecific manner to impair function, forms the underlying premise of most theories of the actions of alcohol upon the brain during the present century. But, at present, no definitive answer as to the mechanism whereby ethanol induces drunkenness or sleep can be given with certainty.

   Although how alcohol causes intoxication may not be known, its ability to damage the central nervous system has been well studied.

   Heavy drinking over many years may result in serious mental disorders or permanent, irreversible damage to the brain or peripheral nervous system. Critical mental functions such as memory, judgment, and learning ability can deteriorate severely, and an individual's personality structure and reality orientation may disintegrate as well.

   With serious brain damage in alcoholic persons, Korsakoff's syndrome may result. In this condition, patients cannot remember recent events, and compensate for their memory loss by making up fictitious events. In addition, these individuals often suffer from polyneuritis – an inflammation of the nerve that causes burning and prickly sensations in the hands and feet. Vitamin deficiency caused by excessive drinking and inadequate intake of nutritious foods appears to be the primary cause of this condition. Vitamin therapy is often used to treat the polyneuritis and memory deficit, although the effects are not always reversible.

   Some studies indicate an increased rate of brain cell damage associated with moderate alcohol intake, while other studies indicate none. Because of the contradiction, this implication warrants further inquiry.

5. Cancer. Studies have implicated the excessive use of alcohol, especially when combined with smoking, in the development of certain cancers. Heavy smoking and heavy drinking seem to be particularly implicated in mouth, pharynx, and larynx cancer where heavy intake of both has not only an additive but apparently a potentiating effect in increasing risk. Cancer of the esophagus is also associated with heavy consumption of distilled spirits. Primary liver cell cancer is more often seen in persons with a history of chronic heavy alcohol consumption. Cancer of the pancreas may also be associated with alcoholism.

6. Alcohol and Nutrition. Malnutrition is commonly observed among alcoholic persons. In recent years this has been more true of those found on skid row, but it is by no means rare among those in better circumstances. One of the main reasons for this is the reaction itself represents an important source of calories. Each gram of alcohol provides 7.1 calories, which means that an average drink of 86 proof whiskey contains about 100 calories. Therefore, heavy drinkers need less food to fulfill their caloric needs. Since alcoholic beverages do not contain significant amounts of protein, vitamins, minerals, and amino acids, they provide only "empty calories," and the intake of the vital elements of nutrition by a heavy drinker may readily become borderline or insufficient. Lack of money may also reduce the consumption of nutrient-rich food by the alcoholic person.

   In addition, even in a person consuming a good diet, heavy alcohol intake can result in malnutrition by interfering with the normal processes of food digestion and absorption. As a consequence, there is inadequate digestion of the food actually consumed. Some of the side effects of gastritis also reduce appetite, thereby lessening food intake. Moreover, alcohol appears to affect the capacity of the intestine to absorb various nutrients, including vitamins and amino acids. In addition, malnutrition itself further reduces the capacity of the intestine to absorb nutrients.

   A particularly dramatic complication of alcohol intoxication is low blood sugar (HYPOGLYCEMIA) which, if unrecognized, may be responsible for some of the "unexplained" sudden deaths observed in acutely intoxicated alcoholic patients. This complication occurs in individuals whose liver glycogen stores are depleted by fasting or starvation, or in those who have pre-existing abnormalities of carbohydrate metabolism.

G. INTERACTION OF ALCOHOL AND OTHER DRUGS

In light of the current interest in drug abuse generally, and the particular emphasis being accorded the problems of alcohol as the most commonly abused drug, it is pertinent to consider the status of the inter-relationships of the use of alcohol in combination with other drugs. An interaction between alcohol and other drugs may contribute to fatal automobile accidents and accidental or suicidal deaths in individuals who have consumed barbiturates or tranquilizers while they were intoxicated. Indeed, more alcoholic persons die from intoxication by drugs other than alcohol than from alcohol intoxication itself. Moreover, both alcohol intoxication and alcoholism may affect the dosage requirements and safety limits of medically indicated drugs—for example, anesthetics in surgery and anticoagulants after heart attacks.

The interaction of alcohol and drugs appears paradoxical. While intoxicated, individuals are more sensitive to many drugs—for example, sedatives and tranquilizers; alcoholic persons when sober are unusually tolerant of many drugs. This is due to the fact that a single large dose of alcohol leads to the inhibition of the metabolism of other drugs, while prolonged heavy intake leads to accelerated drug metabolism.

On the behavioral level, many other drugs when used simultaneously with alcohol are capable of grossly distorting the usual responses expected from alcohol consumption alone. This is due to the combined effects exerted by alcohol and other drugs on the central nervous system.

The interactive result of taking alcohol and other drugs that also depress the central nervous system may be either additive or potentiative. An additive effect is experienced when half-dose of one drug taken with a half-dose of another similarly acting drug produce the same effect as a full dose of either drug alone. A potentiative effect results when half-doses of two drugs taken together produce an exaggerated action that is stronger than the effect of a full dose of either drug taken separately. An example of potentiative effect is the combination of barbiturates and alcohol which produces a depressant effect on the central nervous system that is much greater than would occur from either of these drugs taken alone.

During the past several decades, hundreds of new drugs have been produced and introduced to the public. Many of these drugs are legally obtained only through medical prescription. Others are freely available on drug store, supermarket, and speciality-shop counters.

Many of these drugs when combined purposely or accidentally with alcohol produce unexpected and possibly harmful effects. For this reason, the use of any drug with alcohol should be carefully understood and any questions referred to a qualified pharmacist.

II. THE PATH OF ALCOHOL IN THE BODY

(Further explanation of each area is contained in the main body of this section.) The statement numbers are keyed to the diagram on the following page.

1. Alcohol is taken into the body through the mouth and travels to the stomach via the esophagus. Alcohol, in its initial state, is in a form which can be immediately used by the body.

2. In the stomach, the alcohol is subjected to a number of chemicals. Because it is already in its simplest form, these chemicals have little affect on the alcohol. Much of the alcohol is absorbed into the bloodstream directly from the stomach.

3. The remaining alcohol travels to the small intestine where it is absorbed into the blood.

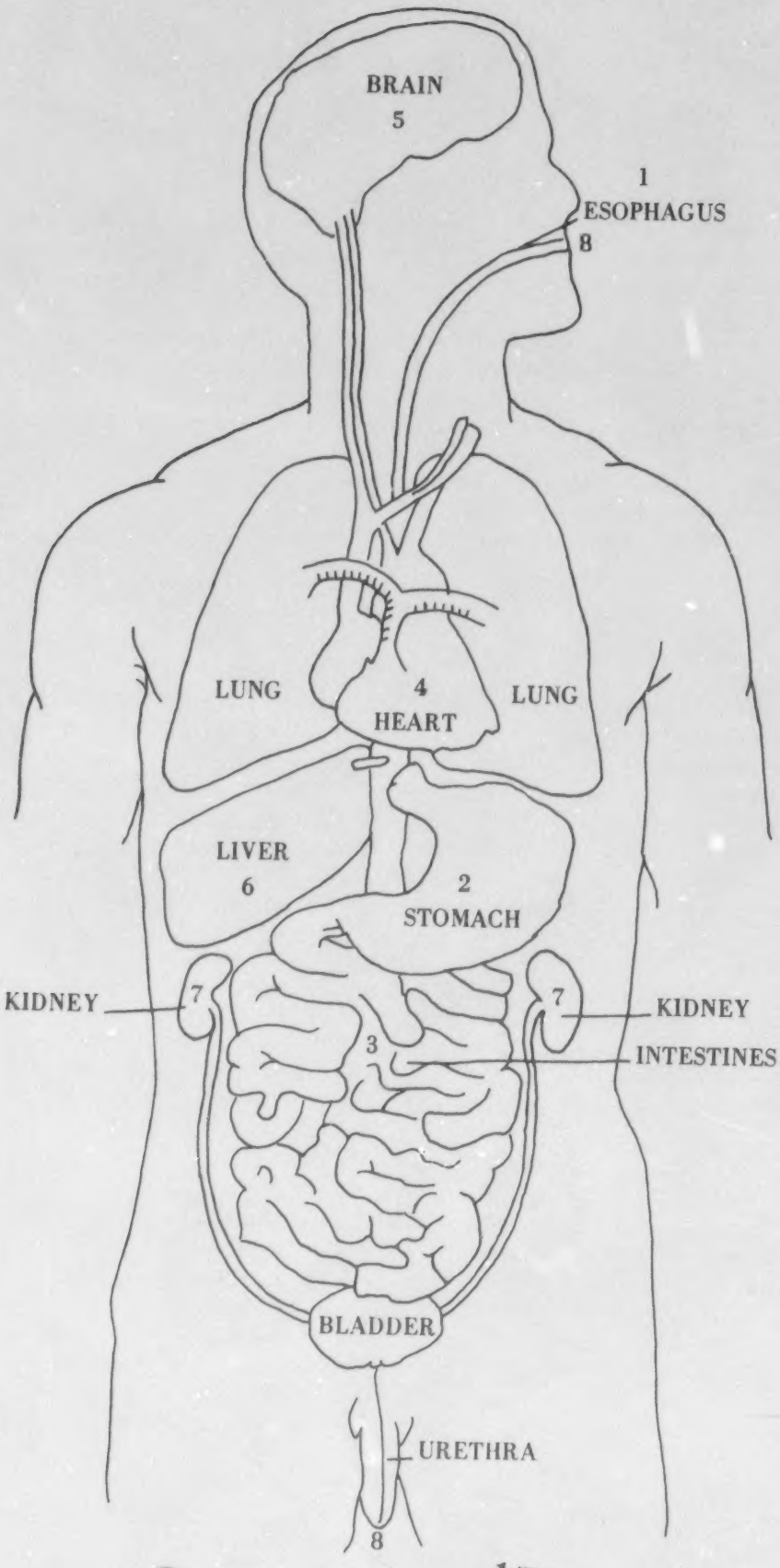
4. Once in the bloodstream, the alcohol travels to all parts of the body. It affects heart rate, blood pressure, appetite, gastric secretion, urine output, etc.

5. Alcohol also affects the brain causing a variety of reactions ranging from relaxation to unconsciousness and death.

6. In the liver, the chemical alcohol undergoes the process of oxidation, whereby it is eventually changed into carbon-dioxide, water, and a release of energy. These chemicals re-enter the bloodstream and move on to the kidneys.

7. The kidneys filter out the end products and the oxidation process, which are finally excreted out of the body.

8. About 95-98 per cent of the alcohol undergoes steps 1-7; however, the remaining 2-5 per cent escapes unchanged via sweat, the breath, and the urine.


BRAIN
5
1
ESOPHAGUS
8
LUNG
4
HEART
LUNG
LIVER
6
2
STOMACH
KIDNEY
7
7
KIDNEY
3
INTESTINES
BLADDER
URETHRA
8

II. BEHAVIORAL EFFECTS

A. OVERVIEW

Alcohol's effects on the brain and nerve cells, and in turn on human behavior, are similar to those of chloroform or ether. The intoxicating action of alcohol affects the brain first, since the brain is highly sensitive even to very low alcohol concentrations. The disturbances which result are shown in the activities of the organs controlled by the brain.

One characteristic of alcohol is, not all the nerve centers in the brain are affected by the same blood alcohol level. Some nerve centers are more resistant than others, and are not affected by low blood alcohol levels. For example, the nerve centers controlling the automatic processes such as breathing are the last to be affected. The first to be affected are the centers controlling the higher functions that have been learned; among these are the inhibitions and judgment. It is always important to remember that the degree to which people are affected is not always reflected in their behavior. Because people react differently to alcohol, there is no way of telling by outward behavior how much alcohol a person has consumed.

B. DEGREES OF IMPAIRMENT

As was stated earlier, the exact process by which alcohol causes intoxication is not clearly understood. However, it is commonly assumed that alcohol works to reduce or depress the functions of nerve cells in the brain. Although the process is not known, the results of that intoxication, which we see as drunkenness, are relatively predictable. Blood Alcohol Level (BAL) is a measure used to classify a person's degree of intoxication. It refers to the ratio of alcohol to blood in the body: e.g., a blood alcohol level of .10 per cent means that there is one part alcohol for every thousand parts of blood. The following blood alcohol levels are based on a 140 pound person who has consumed the alcohol over a short period of time (1-2 hours). Each drink is considered to contain 1 oz. of alcohol, the amount contained in 1 can of beer, 1 shot of whiskey, or 1 glass of wine. It should be clearly understood that these blood alcohol levels and behaviors are approximations, since there are at least 10 factors alone or in combination with other factors which may influence a person's response to alcohol: (See Section C)

Refer to brain diagram on page 28 for the following section:

One to Two Drinks - (.01 to .04 BAL)

The first parts of the brain to be affected by alcohol are the outer layers of the cerebrum. The cerebrum contains the centers of association of the brain, e.g., judgment, reason and inhibitions. The depression of these centers being to a mild degree, when the blood alcohol level reaches .01 to .04. At this stage, a person may become more relaxed and there may be a slight decrease in fine skills, but major changes in behavior are usually not observable at this point.

Three to Four Drinks - (.05 to .08 BAL)

As more alcohol enters the person's blood, its effects begin to reach deeper into the brain tissue, affecting the cerebrum. After three or four drinks, the blood alcohol level reaches

.05 to .08 and begins to produce a feeling of relaxation as deeper areas are affected. At this point, some of the higher motor and sensory areas are also affected. This causes a decrease in fine skills and a reduction of the person's ability to respond and perform. People at this stage are likely to be more talkative, noisy, and moody, and to feel more alert and more capable than normal, when in actuality, there has been a reduction in their reaction time, judgment, and ability to respond to emergencies. Thus, as their actual ability to perform decreases, their confidence in that ability increases.

Five To Seven Drinks - (.09 to .15 BAL)

As the blood alcohol level approaches the .09 to .15 level, the effects of alcohol extend out of the cerebrum and into the cerebellum. This area of the brain is an essential link in coordinating sensory impulses and motor activity. Alcohol's effect here is to greatly impair the person's ability to respond to stimuli. The drinker's sense of hearing, speech, vision and balance are altered. Decreased sense of pain, staggered gait, and slurred speech may also be evident.

Eight to Twelve Drinks - (.16 to .30 BAL)

With eight to twelve drinks the blood alcohol level has reached the .16 to .30 level. The entire cerebellum, which controls perception and coordination, as well as portions of the medulla, which controls involuntary functions, may be affected. Reflexes are depressed, body temperature may decrease, and circulation is impaired. Unconsciousness may occur. At this point, gross intoxication of all physical and mental faculties is evident.

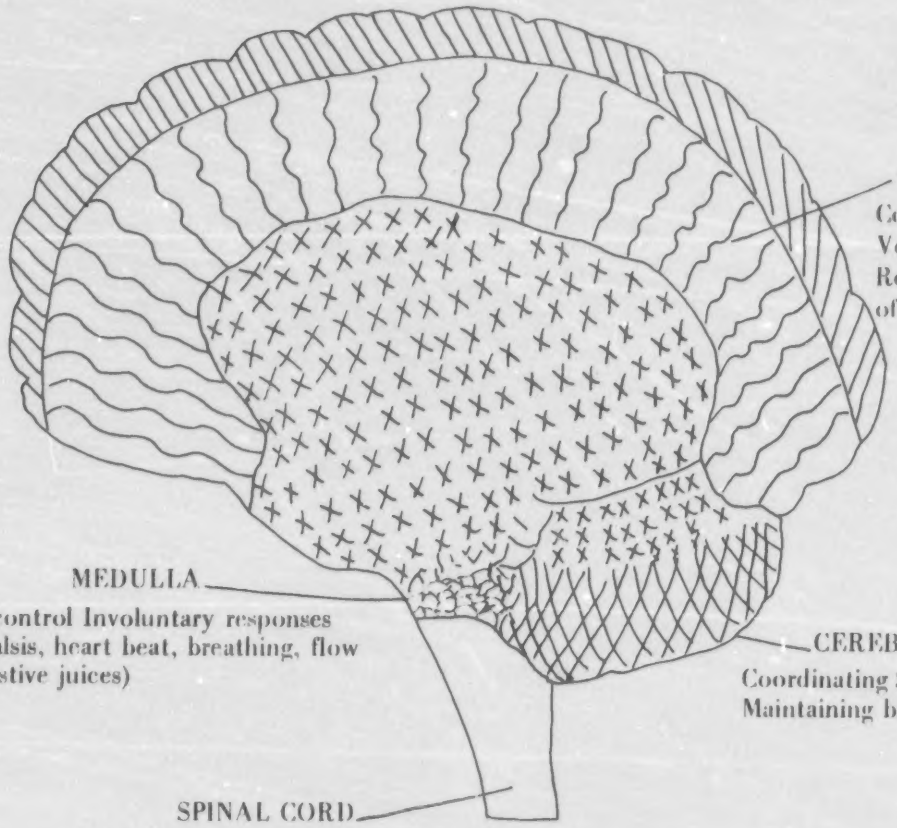
More Than Twelve Drinks - (.30 and Above BAL)

Fortunately, most people in this condition are not in a position to drink anymore. They are usually unconscious and will remain in a coma until the body has disposed of enough alcohol so that the nerve centers controlling consciousness may begin to function again. It is important to realize that drinkers in this condition are near the point of death and may die for one of two reasons if left unattended. One, if there is unabsorbed alcohol in the person's stomach, the absorption process will continue, even though the person is unconscious and can build up the alcohol level in the body to the point of .40 to .50, which is enough to stop the breathing process. A second reason for death while in a coma is vomiting, which may cause the unconscious person to choke. For these reasons, a drinker in a coma should never be left unattended and medical help should be found.

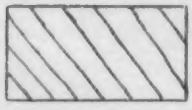
IV, 28

EFFECTS OF ALCOHOL ON AREAS OF THE BRAIN

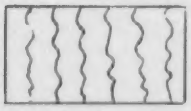
BRAIN


CEREBRUM
Conscious thought, Voluntary Muscle Responses, Control of Reflexes.
MEDULLA
Helps control Involuntary responses (peristalsis, heart beat, breathing, flow of digestive juices)
CEREBELLUM
Coordinating Skeletal Muscle Maintaining balance.
SPINAL CORD
Center of reflexes below the neck

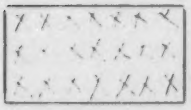
Key For Brain Diagram



One to Two Drinks (BAL .01 to .04)



Three to Four Drinks (BAL .05 to .08)



Five to Seven Drinks (BAL .09 to .15)

Eight to Twelve Drinks (BAL .16 to .30)

*These blood alcohol levels are based on a 140 lb. person who has consumed alcohol over a short period of time (1 to 2 hours.)

C. FACTORS WHICH INFLUENCE THE BEHAVIORAL EFFECTS OF ALCOHOL

When discussing the average effect of a given blood alcohol level on an average person, it is important to keep in mind a number of factors which influence how people respond to alcohol. These factors include: the type of alcoholic beverage, how much of it and how fast one drinks, whether one has eaten, body weight and personal body chemistry, the situation and mood one is in, one's attitudes about drinking, and one's drinking experience. (Explanations of other factors can be found on page 21.)

Here are a few examples:

1. Situation. Often, we unthinkingly regulate our behavior when we're drinking, depending on where we are, and who we're with. A young person, having dinner with a friend, may feel slightly high after one drink. But when having dinner with the boss the next night, one drink may have little or no effect. The individual is keeping a tighter grip on his/her behavior.

2. Mood. People's emotions can also affect their drinking behavior. When at ease and comfortable, they are likely to stop after feeling the relaxing effect of one drink. But at another time, when they are tense or angry, they might feel pressured to continue drinking until their minds no longer focus on their problems.

   People's reasons for drinking can actually affect their reactions to alcohol, too. Someone who is drinking to have an excuse for acting out may unconsciously exaggerate the effect that alcohol is having, while people who boast that they can hold their liquor may succeed in masking the effects of the alcohol.

3. Drinking Experience. Those who are used to alcohol recognize when it is beginning to interfere with their judgment and coordination. Certain reactions warn them when to stop drinking and when to control their behavior.

   Inexperienced drinkers do not have a clear picture of how they will react to alcohol nor have they learned to control their reactions. In fact, since they are expecting something to happen, they may purposely behave with less control. They may also be unsure of when to stop and may drink more than they can handle.

D. DEVELOPING TOLERANCE TO ALCOHOL

There are many people who believe that with practice a drinker can develop a tolerance or resistance to alcohol. They point to the fact that experienced drinkers develop the ability to "hold their liquor" without outwardly showing the effects of it. Since there are so many misconceptions about this, we need to examine more closely just what is meant by tolerance. There are two kinds of tolerance which outwardly appear the same but which actually are quite different.

Tissue Tolerance. There is some evidence that prolonged regular intake of alcohol in large doses can create what is called tissue resistance. The body's nerve centers, in a desperate attempt to keep the body processes functioning in balance, attempt to compensate for the depressant effect of the drug. The more they compensate, the more alcohol must be taken to obtain the same degree of effect. Thus, up to a point, people can develop a resistance in their nervous systems which enables them to offset the depressant action of alcohol. In

that sense, experienced drinkers will be more in command of their faculties than beginning drinkers having the same blood alcohol level. However, such tissue tolerance is developed only after prolonged drinking regularly in more than normal amounts. The average drinker does not develop this tolerance to any significant degree.

Psychological Tolerance. There is another type of tolerance which most drinkers do develop. It is called a psychological tolerance. This is a learning process, not a change in the functioning of the nerve centers as occurs in tissue tolerance. These drinkers learn to compensate for the effects of alcohol much as a sailor learns to walk across the deck of a rolling ship. They learn what to expect so that if circumstances require it, they can control their behavior and perform accordingly. For example, with concentrated effect, some people can walk a straight line even though their blood alcohol level has reached the point of seriously affecting coordination.

It is this psychological tolerance that fools people into thinking that a drinker is sober. That is why by observation alone one cannot determine to what extent alcohol has affected the faculties of a drinker. The fact that they look and act sober does not mean that they are any more capable of skilled performance than the beginning drinker who may appear intoxicated.

ALCOHOLISM

Definition & Theories

According to a major study of American drinking practices, more than two-thirds of the adult population, or about 95 million people, drink alcoholic beverages at least occasionally. The majority of those who drink do so without problems, but there are others whose drinking gets out of hand, endangering themselves and those around them. This group of problem drinkers includes men and women from all socioeconomic classes, backgrounds, religions, races and occupations.

1. DEFINITION OF ALCOHOLISM AND PROBLEM DRINKING

Professionals in the field of alcoholism research and treatment differ in their definitions of problem drinkers. Distinctions are sometimes made between individuals with drinking problems and those suffering from alcoholism—with alcoholics considered to have the more serious problem. Since the two populations are not easy to distinguish, hard and fast differentiations are rarely made.

Within our society, "problem drinking" is usually recognized as drinking to such an excess that the ability to control one's actions and maintain a socially acceptable life style is impaired.

A. Problem Drinking

Several behavioral criteria characterize the person who may have a drinking problem. The following list of criteria, although incomplete, presents some general indicators of problems with alcohol if a person answers "yes" to one or more statements.

1. Anyone who must drink in order to function or to "cope with life".
2. Anyone who by his/her own definition, or that of family and friends, frequently drinks to a state of intoxication.
3. Anyone who goes to work intoxicated or has lost a job due to drinking.
4. Anyone who is intoxicated and drives a car.
5. Anyone who sustains bodily injury requiring medical attention as a consequence of an intoxicated state.
6. Anyone who, under the influence of alcohol, does something he/she would never do without alcohol.

Other experts have noted that the following "warning signs" often indicate that a person is in the early stages of problem drinking or alcoholism: the need to drink before facing certain situations, frequent drinking sprees, a steady increase in intake, solitary drinking, early morning drinking, and sometimes the occurrence of "blackouts" (a period of time in which, while remaining otherwise fully conscious, the drinker undergoes a loss of memory).

Although criteria and estimates vary considerably, it is generally thought that there are about 9 to 10 million people in our country with drinking and alcoholism

problems. Of those, depending upon the definition used, the number of alcoholics has been estimated to be above 5 million.

B. The definition of alcoholism varies depending on who is asked. However, most definitions include components similar to the following:

1. Loss of control of alcohol intake—the victims find themselves drinking when they intend not to drink, or drinking more than they planned;

2. Presence of functional or structural damage—physiological, psychological, domestic, economic, or social;

3. Use of alcohol as a kind of universal therapy, as a psychopharmacological substance through which the person tries to keep his/her life from disintegrating.

These components are expanded in the set of criteria for the diagnosis of alcoholism (too lengthly to include here) compiled by a committee of medical authorities from the National Council on Alcoholism. They are divided into two major sections; (1) Physiological and Clinical and (2) Behavioral, Psychological, and Attitudinal.

II. CAUSES OF ALCOHOLISM

As laboratory and clinical data have become more refined, it has become evident that there are many kinds of drinking problems, many types of people who have them, and many reasons why they begin and continue to drink to a harmful degree.

A 1963 survey found that the percentage of problem drinkers was highest in the western part of the United States, among males, residents of the larger cities, the divorced or unmarried, those with the least and those with the most education, and those with the lowest and those with the highest vocational status. The lowest rates were found among Lutherans, Congregationalist, Presbyterians, Episcopalians, and Jews. Findings from this survey also suggest that drinkers from groups in which drinking is relatively uncommon may be the most likely to encounter trouble because of their drinking. Other research indicates that children who come from homes where parents are either teetotalers or alcoholics have a higher risk of becoming alcoholics than children of parents whose attitudes and behavior are less extreme.

In a 1965 survey of American drinking practices, it was found that whether a person drinks at all depends primarily on social and cultural factors, but psychological factors appear to determine whether or not one will become a "heavy escape drinker" – one who drinks heavily, and uses drinking as a means of escaping from tensions, problems, and depressions. The population of heavy escape drinkers, about 9 percent of all drinkers, contains those most likely to be or become alcoholic and problem drinkers.

The search for a unitary cause of alcoholism has shifted to interdisciplinary exploration of factors that might, singly or in combination account for the development of problem drinking in various types of individuals. Although there is no generally agreed – upon model of how alcoholism starts, research into the physiological, psychological, and sociological factors has resulted in a far greater understanding of the conditions that may precede, underlie, and maintain problem drinking. The state of knowledge is still quite crude. There have, however, been several promising leads which may ultimately contribute

to better prediction and protection of individuals likely to develop alcohol problems, and to improved treatment techniques for those already ill.

A. Physiological Theories

Despite considerable research effort to find physical factors, either in alcohol itself, or in the biological makeup of those who drink, which could account for alcoholic drinking and addiction, to date, many of the questions remain unsolved. Some of the proposed theories are presented here for consideration, including the genetic, endocrine, and genetotrophic theories.

1. Genetic Theory

Some workers in the field theorize that alcoholism may be inherited. Alcoholism appears to run in families; it is, therefore, suggested that an alcoholism prone individual may have inherited a susceptibility to be influenced adversely by ingested alcohol. Research has provided some evidence to support this theory. The possibility that humans may inherit a predisposition for alcoholism or an immunity to it does not rule out other factors also contributing to its occurence in a positive or negative manner. Thus, the development of alcoholism may be the result of a collection of factors rather than just one.

2. Endocrine Theory

Another major physiological theory of the cause of alcoholism indicates a dysfunction of the endocrine system. Similarities between the symptoms seen in alcoholic patients and in patients with endocrine disorders suggest that some failure of the endocrines might be casually related to the onset of alcoholism. If alcohol ingestion stresses the organism, chronic heavy drinking could cause a hyperactivity of the pituitary gland, eventually exhaustion of the adrenal cortex, and, consequently, a breakdown in the functions regulated by the adrenal hormones.

As the other theories, the experimental clinical evidence to date is not conclusive. The available information suggests that the endocrine characteristics associated with alcoholism may be a result of chronic heavy drinking rather than its cause.

3. Genetotrophic Theory

The genetotrophic theory of alcoholism combines the concept of a genetic trait and nutritional deficiency. It is postulated that, due to an inherited defect or "error" of metabolism, some people require unusual amounts of some of the essential vitamins. Since they do not get these unusual amounts in their normal diet, they have a genetically caused nutritional deficiency. Those who drink alcohol develop an abnormal craving for the substance and the consequence is alcoholism.

4. Other Physiological Theories

Other physiological theories about alcoholism include factors such as allergies, differing metabolic rates, and non-alcoholic components of alcoholic beverages (congeners). Although there is a theoretical basis for each, the scientific evidence does not yet exist to support them.

In summary, it is generally held that physiological factors probably contribute to the development of alcoholism, but none has yet been conclusively proven to be the single cause.

B. Psychological Theories

Some researchers believe that individuals with alcohol problems possess a number of distinctive traits which together make up the "alcoholic personality." However, there is no agreement on the identity of these traits, nor on whether they may be the cause or the result of excessive drinking. Three approaches to the psychological cause of alcoholism are explained in this section: the psychoanalytic theory, the learning theory and the personality trait theory.

1. Psychoanalytic Theory

Psychoanalytic explanations of the causes of alcoholism rest on three major theoretical positions: (a) the Freudian view; (b) the Adlerian view; and (c) the view that alcoholism develops as a response to an inner conflict between dependency drives and aggressive impulses.

The Freudian view as expressed by a number of people relates alcoholism to such factors as repressed urges, oral dependency, need for security, self-punishment and parental hatred.

The adlerian view is that alcoholism represents a striving for power, which compensates for a pervasive feeling of inferiority. It is assumed that alcoholics derive their feelings of inferiority from a childhood in which overindulgent parents did not permit them to learn how to cope with the problems of adult life. The alcoholic turns to alcohol to enhance his/her feelings of self-esteem and prowess.

Other studies suggest that frustrated ambitions may play a role in the development of an alcohol problem. It is suggested that alcoholics may have an enhanced need for power, but find themselves inadequate to achieve their goals. They resort to alcohol because it provides a sense of release, of power, and feelings of achievement. Since overindulgence in alcohol precludes effectively coping with the existing problems and leads to additional problems, this vicious cycle results in confirmed alcoholism.

Evidence to support the psychoanalytic views is inconclusive, since it is difficult to devise experimental tests of these theories. Nevertheless, in some cases, the application of psychoanalytic ideas in the treatment of alcoholism has been successful.

2. Learning Theory

Learning and reinforcement theory explains alcoholism by considering alcohol ingestion as a reflex response to some stimulus and as a way to reduce an inner drive such as fear or anxiety. This theory holds that persons tend to be drawn to pleasant situations or repelled by unpleasant or tension-producing ones. In the latter case, alcohol ingestion is said to reduce the tension or feelings of unpleasantness and to replace them with a feeling of well-being or euphoria.

The obvious troubles experienced by alcoholics might appear to contradict the learning theory in the explanation of alcoholism. The discomfort, pain, and punishment they experience should presumably serve as a deterrent to drinking. The fact that alcoholics continue to drink in the face of family discord, loss of employment, illness, and other sequels of repeated bouts is explained by the fact that alcohol has the immediate effect of reducing tension while the unpleasant consequences of drunken driving come only later.

The role of punishment is becoming increasingly important in formulating a cause of alcoholism based on the principles of learning theory. While punishment may serve to suppress a response, experiments have shown that under some circumstances it can serve as a reward and reinforce the behavior. Thus if the alcoholic has learned to drink under conditions of both reward and punishment, either type of condition may precipitate renewed drinking.

Ample experimental evidence supports the hypothesis that excessive alcohol consumption can be learned. However since conflicting studies exist, the learning theory requires further research.

3. Personality Trait Theory

Psychological research has also attempted to define the causes of alcoholism in terms of an "alcoholic personality." Though it is conceded that all alcoholics need not have the same characteristics, it is postulated that in the prealcoholic stage, a personality pattern or constellation of characteristics should be discernible and should correlate with a predisposition toward alcoholism. One of the main difficulties in this approach is that the population ordinarily available for study is already in trouble with alcohol. The question, is whether the personality traits observed in these people predate the onset of alcoholism, or are a consequence of alcoholism.

Using objective and projective tests, researchers have attempted to identify an underlying personality disorder. As yet, these approaches have failed to identify a common personality of alcoholism. There is evidence that alcoholic patients exhibit some personality traits in common. Once the addiction has been established, these patients show some common behavioral and trait manifestations which appear to be more relevant to alcoholism than to other psychological disorders.

C. Sociological Theories

Alcohol serves vastly different functions within and among societies, cultures, subcultures, and ethnic and religious groups. Attitudes concerning its use range from extreme permissiveness to abolute abstinence. But abstainers can always be found when permissiveness is the watchword, and conversely, drinking does not disappear when abstinence reigns. The purposes for which alcohol is used include religious, culinary, psychic, ceremonial, hedonistic, traditional, social and medicinal ones. Standards of acceptability applied to the manner or pattern of drinking vary according to the age, occasion, sex, cultural background, social class and the particular circumstances.

1. Cultural Theory

The cultural theory of alcoholism suggests that within a given society, there are

three ways in which the culture may influence the rate of alcoholism:

a. The degree to which the culture operates to bring about inner tensions or acute needs for adjustment in its members;

b. The attitudes toward drinking the culture produces in its members;

c. The degree to which the culture provides suitable substitute means of satisfaction.

Societies may provide alternatives to or substitutes for alcohol use. Some societies have less stringent sanctions against narcotic drugs and therefore, have a lower alcoholism rate. Others permit emotional outlets through ceremonies and rituals and thereby provide culturally accepted means of anxiety reduction.

2. Deviant Behavior Theory

Depending on the context, the use of alcohol can be illegal or only illegitimate . . . acceptable or even sanctified . . . forbidden or abominated. Thus, the concept of alcohol abuse as deviant behavior is receiving increasing attention by researchers. The deviant behavior theory represents the alcoholic as someone who, through a set of circumstances, becomes publicly labeled a deviant and is forced by society's reaction into playing a deviant role.

D. Summary of Causes of Alcoholism

The search for a single cause of alcoholism may be an unrealistic goal. Nevertheless, researchers with specialized interests, and with needs to define alcoholism from their own perspectives, will probably continue to look for a unitary answer to solve the problem of how alcohol addiction occurs and to identify the crucial factors associated with its onset and progression.

Many theorists, however, suggest a multi-faceted approach which incorporates elements from two or more hypotheses. Generally, such an approach selects from each of the broad areas discussed; physiology, psychology, and sociology.

An individual who (1) responds to beverage alcohol in a certain way, perhaps physiologically determined, by experiencing intense relief and relaxation; and who (2) has certain personality characteristics, such as difficulty in dealing with and overcoming depression, frustration, and anxiety; and who (3) is a member of a culture that induces guilt and confusion regarding what kinds of drinking behavior are appropriate, is more likely to develop trouble than will most other persons.

More research will have to be done to gain deeper insight into the causes of alcoholism. Work is needed to identify better the association between alcohol use and all aspects of physiological responses, predispositions and attitudes, and the social consequences of drinking.

SYMPTOMS OF CHEMICAL DEPENDENCY

The Life Powers Wheel

The following pages make references to symptoms that affect the "life" and "relationships" of the chemically dependent person.

The concept of life powers is explained on the first page. Life powers represent a whole and integrated person. Chemical dependency becomes symptomatic when the life powers become seriously maladjusted and distorted.

All crisis situations, coping with large or small problems, cause a degree of readjustment and possible maladjustment for any varying length of time. Chemical dependency causes distortion, readjustment and progressive maladjustment due to the drug relationship and pathological dependency.

LIFE POWERS

Normal Adjustment In The Wheel

The wheel represents "Life Powers", my whole being, what I am made up of. I need to think, make judgements, etc., and that is my MENTAL make up. I can feel good or bad, happy or sad, and that is the EMOTIONAL me. PHYSICALLY, I'm a girl of so-and-so weight, height, build, etc. My VOLITIONAL life powers me to wish to achieve at school or work to secure some success and fulfillment in life. SPIRITUALLY, I feel that I am capable of acting right or wrong. If I act out in a way that I feel is wrong, I have to live with the conflict of feeling bad or guilty because I behaved in a way that didn't match MY value system.

Normal shifts and compensations occur for obvious and necessary reasons.

Example: The Hearing Problem

Joe is 14 and the school nurse just picked up a serious hearing impairment. Joe has had problems in his life, but he has been compensating..

Mentally –	Math and Science grades have dropped. Joe didn't know he wasn't hearing all the teachers were saying.
Emotionally –	Hurt, lonesome, angry. Classmates have teased Joe, girls think Joe's pretty slow - at everything.
Physically –	Joe lifts weights, excells in football, made first string on the team, etc.
Socially –	Joe may have had troubles with friends at school, but Joe has a few good friends and his family loves him and vice-versa.
Volitional –	Joe had given up on math and science, but Joe liked carpentry. He was creative and a perfect detail person - without blueprints and instructions.

Student Activities

1. How would you draw Joe's life wheel?
2. How would you think it would change if Joe got a hearing aid, surgery, etc.?
3. Do you think the changes, coping, compensation measures took a while in coming about? How soon, if ever, do you think Joe's wheel would balance out normally (whatever normal is?) Explain your prediction.

Teacher Activity

The teacher may draw Joe's life wheel - before and after - and will proportion the segments as he/she perceives the degree of compensation. Explain to the class the hypothetical nature of the activity, therefore proportions are neither right or wrong.

CHEMICAL DEPENDENCY A DISEASE

Chemical dependency is essentially a pathological or sick relationship of a person to a mood - altering chemical substance, a psychoactive drug, in expectations of a rewarding experience. (Robert M. and Mary B. McAuliffee, PHD's) This definition refers to a pathological, sick, ill, diseased, etc. deviation from normal health caused directly by that person's relationship to a drug to chemically and powerfully change the way he/she "feels". The process of development progressing into destructive events or resulting conditions are the elements of a pathological dependency.

AREAS OF LIFE AFFECTED:

1. Spiritual
2. Mental
3. Emotional
4. Physical
5. Social
6. Volitional

or

1. Emotional
2. Social
3. Physical
4. Economic
5. Legal
6. Spiritual

These psychic or life powers may be summed up conveniently as a "powers wheel" or a "circle of life." The human person acts through or by means of these powers to carry on activities in various areas of life.

Psychic (Life) Powers Wheel

Activity, Function in the area of spiritual life, ethics, religious values and behavior

Activity, function in the area of volitional or will power life: free choice of goals and means.

Activity, function in the area of mental life throughout, fantasy, memories.

Activity, Function in social life interpersonal relations and communications.

Activity, function in the area of feeling life pursuit of good, avoidance of evil.

Activity, function in the area of physical life especially sensation.

Chemical dependency is a complex, many-faceted illness affecting the whole person. It is a total-person illness because the drug relationship involves both the person as a whole and all of the person's life powers.

The whole person and all of his powers are engaged in the making of the initial drug commitment.

HOW CHEMICAL DEPENDENCY AFFECTS THE LIFE POWERS WHEEL

There are symptoms of Chemical Dependency that distort the normal balance of the life power wheel. The previous illustration of healthy readjustment is quite different from the pathological or "sick" way a chemically dependent person adjusts, readjusts, and maladjusts his/her life due to the strong commitment of a drug oriented relationship.

There are degrees or stages of readjustment and maladjustment which will be explained later, but there are symptoms like sign posts that flag and help identify the disease process. Symptoms vary in degree because the individual's motivation or expectation of the drug experience changes. To diagnose or identify the nature of the disease chemical dependency, one needs to look at the symptoms and examine the abnormalcy of the thought and behavior looking at the person as a "whole" unique individual.

Psychological Dependency	– Life style is drug oriented – Always talks about getting drunk or high – Takes a drug-like medicine to feel better – Arranges finances to afford the needed drug
Mental Obsession	– Becomes uneasy when drug supply is low – Is irritated when drinking or use of drug is interrupted – Gulps, chugs or sneaks drinks – Forgets plans or promises in order to start or continue using drug
Low Self Image	– Is dishonest, lies, give alibis regarding drug involvement – Steals in order to buy drug – Expresses guilt, shame, embarrassment, etc., about drug induced/drug related behavior and does it again – Pleads for sympathy, understanding, forgiveness after drug related incident
Rigid Negative Attitude	– Highly suspicious and critical even paranoid that others may be judging his/her drinking or using or behavior – Becomes easily discouraged or depressed and uses drug to feel better – Is intolerant of others' ideas and opinions, becomes resentful and drinks or uses another drug to relieve frustration – Has an inflated ego or becomes very selfish especially when using the drug
Rigid Defense System	– Denies or defends drug use or drug involvement – Denies feeling guilty about consequences of drug use – Attacks those who threaten the drug use or drug involvement – Denies drug induced anti-social behavior

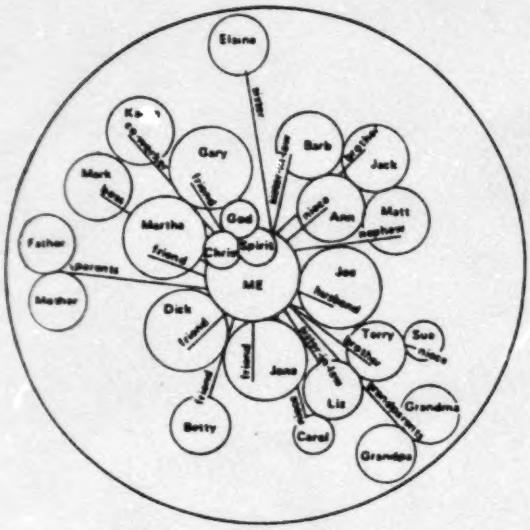
Delusion	– Seems to be unaware of need and dependency of ingestion – Seems to be unaware of deteriorating interpersonal relationships because of drug use or drug induced behavior – Appears to be sincere in blaming others for drug-related problems – Sincerely believes "I can take it or leave it", "I can quit anytime"
Powerlessness	– Has repeatedly gotten drunk or stoned – Appears to feel ashamed about manner of use, but does not change it – Appears unable to live up to own personal values and standards because of drug use – Has changed job, friends, classes, etc., hoping to solve problems, but can't because of drug use
Physical	– Appears to hold liquor or handle drug highs well – Sometimes vomits, sweats or gets shaky after drug use or when use is delayed – Sometimes can't remember getting home after using drug – Sometimes only remembers feeling good, but can't remember details of drug related episode

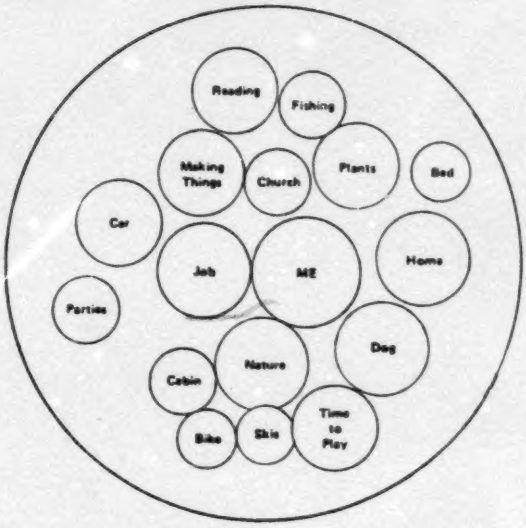
Note to teachers: The symptoms listed above are obviously not the standard twenty symptom list you may have seen before. This listing looks at the entire and uniquely individual symptoms of chemical dependency. This list is not complete nor prioritized, but there are indications of progression. An individual who is, potentially is, or was chemically dependent will sometimes exhibit these symptomatic behaviors and thought processes. The key for identification of the illness is still - Repeated - Problems - Connected With or Caused by the Drug Use!

Class Activity

The teacher may draw a Life Powers Wheel and have the student slot in symptoms of chemical dependency and explain how these symptoms would distort all areas of the life.

LIFE RELATIONSHIPS WHEELS

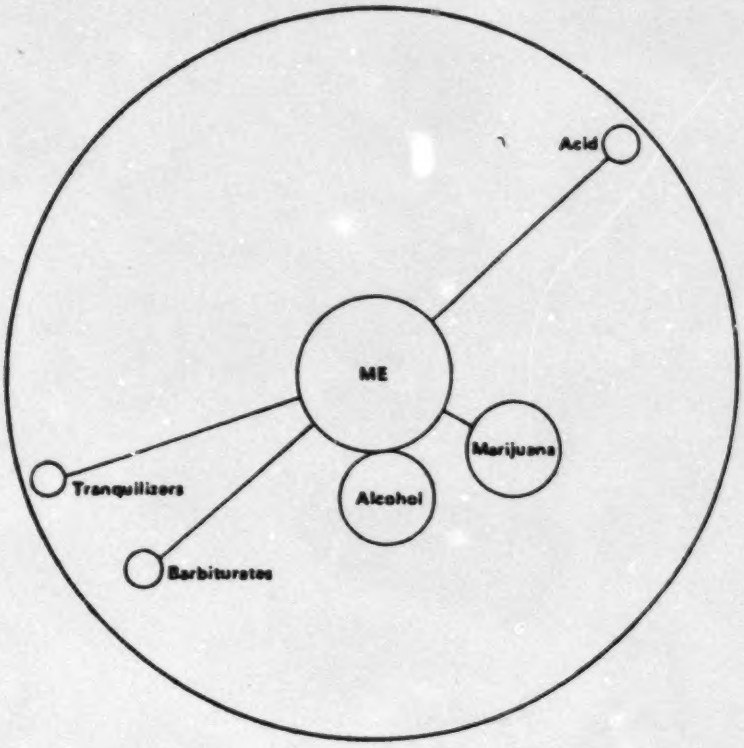




EXPLAIN

With Chemical Dependency, a powerful mood-altering chemical will significantly change the way one feels, perceives and acts. Normal human beings relish variety in relationships and usually have a variety of wholesome relationships. There are normal changes in relationships with people and things. If one relationship becomes so overpowering that it damages or destroys the others, then the relationship becomes sick or pathological and we need help and healthy change. Dependencies may be noted in many relationships and although these are similiarities, they are <u>not</u> equal. With chemical dependency, the powerful committment to the drug experience or reward eventually and progressively becomes more pathological by endangering life powers of the individual and adversely affecting all other relationships.

PERSON-TO-DRUGS RELATIONSHIP MAP



When a drug or any combination of powerful mood-altering chemicals prioritizes the life relationship wheel, then people and things who threaten the drug use are progressively moved farther out of the wheel. Many times someone who is close to or concerned about the chemically dependant person's radical changes in relationships, but C.D. denies, blames or seems unaware of the changes. The chemically dependant will usually draw those who use the drug and those who enable the drug use and behavior closer to the center of the wheel.

Class Activity

The teacher will draw a Life Relationship Wheel and using the "Orange" example have the class explain how the "Orange" (may add grapes and bananas as other drugs!) dependency had affected other relationships in the boy's/girl's situation.

ALCOHOLISM IS MUCH DISCUSSED, AND ALCOHOLICS ARE PRESENT IN EVERY COMMUNITY. HOWEVER, FEW SOCIAL WORKERS HAVE THE SPECIALIZED KNOWLEDGE AND SKILLS FOR COUNSELING PERSONS WITH THIS ILLNESS. THE SOLID SUGGESTIONS IN THIS ARTICLE GREW OUT OF LONG EXPERIENCE IN WORKING WITH ALCOHOLICS AND TRAINING OTHER PROFESSIONALS TO WORK WITH THEM.

COUNSELING RECOVERING ALCOHOLICS

By Jon Weinberg

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The magnitude of the problem of alcoholism—which afflicts about 5 percent of the population over 15 years of age—is gradually coming to the attention of the public. In general, those in the helping professions have contributed relatively little toward effective intervention in the problem, primarily because their training has not provided a basic understanding of alcoholism.

This article focuses on treating recovering alcoholics—those who recognize their illness, have stopped drinking because they realized the central role it was playing in their difficulties, are currently sober, and intend to maintain sobriety. The term "recovering" is used instead of the more typical "recovered" to stress the chronic nature of the disorder and the patient's eternal susceptibility to relapse.

Many sober alcoholics do not seek counseling because, when their illness is arrested, they return to their premorbid level of adjustment, in which they were reasonably healthy. Others do not seek it because they are successfully following a program of recovery such as Alcoholics Anonymous (AA), which has a strong mental health component. Some who need counseling avoid it. They believe, often with considerable justification, that their potential counselor might not be knowledgeable about alcoholism and might even do them more harm than good.

However, a considerable number of alcoholics do seek counseling after attaining sobriety, and some stop drinking during treatment. The suggestions for counseling given in this article are designed to make professional social workers more aware of the special problems of the recovering alcoholic, to help them avoid common pitfalls (such as identifying alcoholism as secondary or symptomatic, rather than the primary disorder), and to point out techniques and attitudes that have proved effective.

FAMILY INVOLVEMENT

Alcoholism has usually been described as a family illness. This does not imply as many believe, that the spouse is in some way responsible for the alcoholism. Rather, it means that other family members, especially the wife or husband, are caught up in the pathological processes of the alcoholic's illness in such a way as to develop parallel emotional and/or behavioral problems. Successful treatment for the recovering alcoholic often hinges on involving the spouse effectively in the counseling process. (1)

It is obviously preferable to involve the spouse directly—through joint counseling interviews, for example—but this is not always possible. When it is not, the counselor, with the client's knowledge, is strongly advised to maintain at least occasional telephone contact with the spouse. Self-delusion, or at least marked rationalization, which develops along with the more visible aspects of the illness, is a cardinal feature of alcoholism. Thus, it is virtually imperative for the counselor to have an independent source of information about the client's behavior outside the interview situation. The client may be reporting sobriety when he has been drinking; or he may indicate that everything is rosy at home when he has actually been moody and irritable, perhaps getting close to a slip.

Without independent information, the counselor may be falsely lulled into a feeling of optimism, which would be followed by resentment ("I was conned") if ultimately disastrous

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1. John F. Mueller, "Casework with the Family of the Alcoholic", Social Work, 17 (September 1972) pp. 79-81.

events occurred as a complete surprise. Counselors whose values make them rankel at such "prying" into the client's life beyond the interview may be more successful with nonalcoholics.

One problem frequently encountered in the early phases of recovery is the disappointment or resentment stemming from unrealistic expectations. The alcoholic often expects the family to greet his sobriety with the utmost enthusiasm and gratitude. Unfortunately, the family has been previously conditioned by a thousand broken promises, and may be skeptical or distrustful rather than thrilled. The alcoholic in turn feels let down and angry. Similarly, the family may expect the sober alcoholic to begin functioning at full capacity, to "make up for lost time"; the ravages of the illness. The alcoholic is taught in recovery programs such as AA to put sobriety ahead of everything, including his family. This may necessitate frequent attendance at AA meetings, avoidance of overwork, and other therapeutic measures. The family may not believe that these activities are vital to recovery. The counselor's role is to help the alcoholic and his family understand and accept the feelings each has, and educate them regarding appropriate expectations, always emphasizing the patience both sides must have to deal with a serious illness that was years in the making.

A special caveat is in order with respect to women alcoholics who are married. Many husbands of recovering alcoholics deal with the problem of alcoholism largely by denial, unlike most wives of alcoholics, who more typically try sincerely to be cooperative and understanding. Although the husbands may acknowledge the improved behavioral functioning in their wives, they often resist the use of the alcoholic label or only pay lip service to it. A man may consider his wife's alcoholism a blow to his pride, and if he is a heavy drinker, her abstinence may be a threat. The increasing self-confidence and independence that is likely to accompany her lengthening sobriety often poses an additional threat.

The counselor should attend closely to such factors, working directly with the husband when possible. Since the husband of an alcoholic seldom makes himself available to the counselor, the wife should be helped, as far as possible, to avoid feeling discouraged or sabotaged by the lack of understanding and support. She is more likely to have to depend on herself and other sober alcoholics for the reinforcement needed to maintain recovery.

THE FALLACY OF REASONS

Both the genesis of alcoholism and its optimal solution are extremely controversial issues. Most people in the helping professions (and the public at large) have a strong bias toward the view that alcoholism is psychogenic and that its solution primarily involves unraveling presumed psychological roots of the disease.

The author's position, by contrast, is that intrapsychic factors alone do not account for alcoholism and that the search for its psychological origins cannot provide an appropriate or effective solution. Further, he believes that, with some exceptions, alcoholics have a genuine illness with biological and cultural as well as psychological factors in the etiology.

An enormous amount of evidence has accumulated from research, which unequivocally contradicts the notion of an "alcoholic personality", but many mental health professionals cling tenaciously to this myth. (2)

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2. Edwin H. Sutherland et al., "Personality Traits and the Alcoholic". A Critique of Existing Studies, "Quarterly Journal of Studies on Alcohol, 11 (1950), pp 547-561; and L. Syme, "Personality Chracteristics and the Alcoholic: A Critique of Present Studies," Quarterly Journal of Studies on Alcohol, 18 (1957), pp. 288-302

The view that alcoholism is a complex, chronic disorder without an established etiology has several implications. The counselor should remember that a great many disorders are successfully treated even though the etiology is obscure. What does successful treatment involve? What are the priorities? Sobriety—not simply healthy psychological functioning—must be given primary consideration because it seems that an abnormal reaction to alcohol is a life-time proposition for the vast majority of alcoholics. The evidence at present suggests that no matter how well psychologically alcoholics may become, few can ever return to social drinking.

Although the causes of alcoholism have not been established, the counselor can profitably examine the reasons for drinking, about which more is known. The reasons for drinking are not equivalent to the reasons for alcoholism; they do not explain alcoholism, nor are they necessarily abnormal in any way. In fact, virtually all the reasons why alcoholics drink are the same as the reasons why many nonalcoholics drink at times.

The counselor should become familiar with these reasons so that he can help the recovering alcoholic be on guard for the stimulus cues that are likely to precipitate a response of alcohol or other drug use. In other words, the counselor can forewarn the recovering alcoholic of what he can anticipate and can point out alternative responses and guide him toward them, thus offering constructive help in avoiding relapses. For example, both alcoholics and nonalcoholics may drink to become more relaxed and voluble at a large social function. In recovery, the counselor can help the alcoholic by teaching him how to be socially comfortable at a party without using chemical aids. Similarly, having a few drinks to relieve tension after a hard day at work is a habit the culture generally condones, but alcoholics in recovery must learn other strategies for unwinding.

It is important to note that, as the examples demonstrate, the recovering alcoholic must strive for superior, not average, emotional adjustment because in our society the average person at times uses alcohol and other drugs instead of interval coping mechanisms. This is a luxury the sober alcoholic cannot afford.

ALIBIS AND ANTABUSE

A cardinal feature of alcoholism is the alibi system that the alcoholic must develop to maintain addiction. This is, a person must become delusional in the sense of denying reality and blaming factors outside himself for the terrible problems actually produced by the drinking; otherwise, he would be forced to give up the chemical—hardly the solution an alcoholic prefers. However, the alibi system does not automatically fade away with sobriety.

Since most alcoholics stop drinking under great pressure by their families, their employers, or the courts, or under the duress of some situation that has precipitated a crisis, they may still fail to perceive reality and instead blame their "rotten spouse", their "bigoted boss", or the unfair judicial system.

A person with such delusions, although reluctantly sober, is not yet a recovering alcoholic because he has not recognized his illness as the source of his difficulties. The counselor should treat such a person essentially the same as he treats a practicing alcoholic—that is, teach him about the illness and help him to see reality in terms of the harmful consequences of his drinking.

The alibi problem also occurs with those who are in recovery and even with those who have

long been sober. This is called "stinking thinking" in AA terms, and counselors should be aware of some of the many forms it may take. These include:

Minimizing retrospectively the harmful consequences of drinking: "I was never that bad."

Attributing alcoholism to factors no longer present, thus implying that the illness may have waned: "That job I had would make anybody an alcoholic."

Suggesting that a beverage with a lower alcoholic content will be safe: "A little wine with dinner won't hurt me, and besides, my husband will be happier if I join him."

Showing self-pity: "Nobody understands how rough it is for me."

Clinging to resentments or blaming others: "Those kids of mine had just better straighten out, and my wife too."

Disparaging or avoiding his AA group: "Those people at AA are really hypocrites. Anyhow, I can't go Monday nights during football season."

Those examples of the resurgence of the alibi system are a signal that relapse may be lurking around the corner. It is critically important that the counselor not only avoid reinforcing these often seductively plausible rationalizations, but also make a direct, persistent attempt to bring the person's thinking back to reality. This may require a combination of forceful confrontation and diplomatic delicacy that will tax the counselor's ingenuity. The counselor must remind the client of the nature of his illness and show him that his thinking in alibis is preparing him for drinking again. At the same time, the counsel has to maintain an atmosphere of acceptance that will encourage the client to continue to counseling process.

A special word is in order about clients who are on Antabuse (disulfiram), an inexpensive deterrent drug taken daily that causes an extremely unpleasant physical effect when any alcohol is ingested. In general, the counselor should consider highly suspect any decision that the client makes on his own to discontinue this medication. The client may give an extremely plausible reason—such as "I am doing so well now, I just don't need it"—but in most cases he is planning to drink even though he is not aware of it.

The counselor should try to persuade the client to delay his action for an arbitrary period, perhaps two or three months, and then the decision can be jointly reconsidered. If he insists on discontinuing the drug, the counselor can explain the dangers of the unconscious alibi system, but should not be surprised if the client relapses before the next counseling session.

ROUTINE AND REST

The collective experiences of alcoholics—and of those who work with them regularly—have yielded a number of common-sense conclusions that few professional counselors are aware of. (3) These may sound trivial, but they often spell the difference between maintaining sobriety and relapsing, especially in the first year or two of recovery, and for many even far beyond that.

A primary point is related to changes of routine. It is best for the recovering alcoholic to

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3. Elizabeth D. Whitney, Living With Alcoholism (Boston: Beacon Press, 1968)

develop a stabilized life routine, and most do so. A drinking problem arises when something unusual or different occurs. Two important examples are business trips out of town and any type of vacation, from a weekend at a nearby resort to two or more weeks far away.

Frequently environmental changes seem to awaken a desire for drinking, and the counselor should discuss the risks in advance with the client. Similarly, the client should be prepared for an inclination to drink whenever a change in job, a move to a different neighborhood or town, or some other important shift in scenery or routine is impending. The counselor should make certain that clients who are in AA are informed about meetings in places they will be visiting while away from home, and attendance should be strongly encouraged.

Another important caution involves rest. It is fairly typical for the recovering alcoholic to be an unusually hard worker. In some instances, in his zeal to make up for lost time, he tackles more than he is physically capable of, with resultant fatigue and a greatly increased risk of relapse. The counselor should generally advise a client to forget trying to do two taxing jobs even if he is debt ridden. He can instead pay off the creditors more slowly. Or the housewife and mother of five might well be counseled to leave the kitchen floor for another day instead of laboring until midnight. Naturally, the rest of the family should be helped to understand the necessity for putting the alcoholic's sobriety first.

FLARE-UPS AND FLASHBACKS

The early phases of recovery from alcoholism involve a complex physiological readjustment of the organism to an unaccustomed state—a state of complete freedom from ethyl alcohol. A variety of medically significant laboratory findings are typically noted immediately after withdrawal, but within several weeks such conditions generally return to normal.

Clinical observation suggests that a physiological rather than an environmental hypothesis better accounts for sporadic abnormalities in psychological state that some alcoholics experience during recovery. (4) These abnormal states, which may be called flare-ups, typically include general irritability, tension, and/or depression. Their cardinal characteristic is a complete lack of any reasonable psychological explanation. On the contrary, they occur with fairly sudden onset in spite of the most favorable environmental circumstances.

A farther diagnostic clue—which favors a physiological etiology—is the tendency for such states to occur for most people at specific time spans during recovery. Flare-ups most frequently occur from the fifth to the seventh week, from the fifth to the seventh month, and from the eleventh to the thirteenth month of the recovery period, but there are wide individual variations. They usually pass within a few days.

The counselor should be aware of this phenomenon in order to warn clients and reassure them by stressing the trasitory nature of flare-ups. Clients will otherwise feel bewildered and discouraged, since their efforts to recover seem sabotaged, and relapse is a threat. The wise counselor will not only avoid compounding the problem by insisting on a search for psychogenic explanations, but will explain the flare-ups before they arise.

Recovering alcoholics often have anxiety dreams in which they are drinking. Or, despite not

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4. J. Milam, The Emergent Comprehensive Concept of Alcoholism (Seattle, Washington, Alcoholism Center Associates Press, 1972)

drinking, they may wake up with a hangover feeling, especially after a party. Or they may experience in other episodes the kinds of feelings formerly elicited by drinking. All these phenomena may be conveniently labeled flashbacks. Again, the counselor needs to reassure the client about the normality of the occurrence, carefully avoiding psychodynamic speculations.

HUMILITY

A pervasive goal in most psychological counseling is enhancing the client's self-esteem, which is nearly always low—and alcoholics are certainly no exception. Counseling the recovering alcohol-dependent person does, however, introduce an apparent paradox with regard to ego-building; for successful recovery, both self-confidence and humility must be sought. A comprehensive understanding of alcoholism is needed to appreciate fully the critical importance of humility, but a brief rationale may be helpful.

In his illness the addicted person becomes completely self-centered and even grandiose. He believes he can manage his life if others do not interfere. Usually recovery can begin only after his life has begun to crumble in one or more ways and he has finally abandoned the delusion that he can manage everything. Once in recovery, he must continue to acknowledge that a host of people, events, and conditions influence what happens in his life.

Failure to attain and retain this humble perspective of his power to control his own life usually leads to a return to what AA calls "the big I," or the grandiose idea that one has total control. This is quickly generalized to the use of alcohol or other drugs—which of course "I" can manage—and the result is relapse.

Although some alcoholics, by single-minded involvement with AA, do seem to combine grandiosity and sobriety successfully, this is unlikely to occur among clients who seek counseling.

In practice, the counselor should have little difficulty in directing the client toward both self-esteem and humility. He works to build self-esteem by helping the client to accept himself as a worthwhile person, recognize his assets, set reasonable goals.

The counselor works to develop humility by emphasizing recognition of reality. He may point out examples illustrating that people do not fully control outcomes in their lives:

> An executive intends to be on time for an appointment but a traffic snarl makes him an hour late.
>
> A father plans to take his family on a picnic but thunderstorms upset the plan.
>
> A student studies hard for a test but an attack of flu impairs her performance.

Above all, the alcoholic cannot control the outcome of his drinking. His illness renders him as powerless over the effects of alcohol as the diabetic is over the effects of excess sugar.

MORALITY

Counselors are usually well aware that their own values and attitudes influence the way they

interact with their clients. Experiences derived from counseling alcoholics suggest that moral values are especially significant to this population. The great majority of sober alcoholics seem to have traditional, often somewhat rigid moral values, even though the active stages of the illness have brought about the temporary deterioration of such values.

The most effective counseling strategy for alcoholics is to reinforce behavior consistent with their conventional values, unless these are demonstrably self-defeating and therefore desirable to modify. The counselor should recommend that they avoid behavior contrary to their values, because it is highly probable that even relatively low levels of guilt may precipitate a relapse into drinking. While other types of clients may be quite willing to suffer mild or moderate degrees of guilt in order to reap the benefits of "immoral" behavior—and may occasionally drink to relieve guilt without getting into serious trouble—the recovering alcoholic should be encouraged to live up to his own values scrupulously.

The two most common problem areas are honesty and sex. Dishonesty or cheating whether in job applications, income taxes, interpersonal behavior, or other aspects, poses a real hazard to recovery. Even when signs of guilt are eventually not evident, guilt feelings, often unrecognized, tend to grow and eventually erupt in the form of relapse. With regard to sex, the counselor should adopt a highly conservative stance. Any nonmarital sex relations contrary to the values of recovering alcoholics carry an enormous risk. If both partners in a relationship that is counter to their values are chemically dependent, a joint relapse is a near certainty.

In addition to the guilt component, many alcoholics (especially women and homosexuals) have developed a strong association between "illicit" sex and a state of intoxication. Engaging in the former will be likely to awaken a craving for the latter, with disastrous results. Although he may have a long-range counseling goal of helping the client adopt new values or of breaking up old behavioral associations, the counselor must focus primarily on steering the alcoholic toward keeping sober. This means the client has to move with the utmost caution in the area of morality.

RELAPSES

Because alcoholism is a chronic disease, its victims are subject to relapse throughout their lives. Some counselors may believe that a cure is possible. But the majority accept the fact that sobriety for any length of time is not insurance against a return to the destructive consequences of drinking. Most alcoholics do in fact experience one or more relapses during the recovery process, especially in the first two years. Disastrous slips after twenty years or more of sobriety are by no means unknown.

The attitudes and actions of the counselor may be critically important when his alcoholic client has a relapse. A major hazard is that the counselor may reject the client, overtly and covertly. Since most social workers intellectually accept the chronic nature of the disorder, rejection probably originates in latent moralistic attitudes toward alcoholism. Or a counselor's rejection of an alcoholic may be derived, at least in part, from a sense of inadequacy because of the client's apparent failure to benefit from counseling.

To ascertain his real feelings about alcoholics, the social worker might ask himself the following questions:

> How do I react when clients with other types of chronic problems take a turn for the worse?

Do I get angry, for example, at a chronic schizophrenic who stops his medication and must be rehospitalized?

Do I condemn the obese client who departs from his prescribed diet?

Do I denounce the borderline student who fails to adhere to the agreed-upon study schedule?

If the answer to these questions is yes, then the counselor should look at his own self-concept in relation to his professional role. If, however, he does not feel angry and rejecting toward some types of clients, but does toward the relapsing alcoholic, he has yielded to the entrenched cultural attitude of judging his client as morally inferior and thus unworthy or unmotivated.

It is worth remembering that our society generally stacks the deck in favor of relapse. Although the alcoholic's sobriety initially delights the family and most other people important in his life, they tend after a time to assume that the problem has ended, that the person is cured. Sooner or later well-intentioned but uninformed friends and relatives will encourage or even pressure recovering alcoholics to try drinking "like gentlemen or ladies" now that they have "reformed."

The power of social conformity may jeopardize recovery as much or more than the internal psychological stresses on which most counselors focus.

The counselor's role when relapse occurs is to help interrupt the drinking, if he has an opportunity to do so. He may assist by advising the family to take forcible action, since the client is not likely to be available to him. He should also avoid condemnatory judgments when the client returns and help the client examine the probable causes of the relapse with an eye toward future prevention.

ALCOHOLICS ANONYMOUS

Professionals typically have mixed feelings about AA. On the one hand, nearly everyone acknowledges the superior effectiveness of AA in comparison with professional mental health treatment for alcoholics. (5) On the other hand, for varying reasons, counselors tend to have negative feelings or at least serious reservations about the AA approach. Some feel it is too religious. Some suggest that it involves too much dependence or rigidity. Others object to the zealous or smug attitudes of some AA members.

The author believes that AA offers an outstanding program, both for recovery from alcoholism and for general emotional adjustment which those counseling the alcoholic should strongly endorse. Careful study of the Twelve Steps of AA reveals the following major components, telescoped and grouped for the sake of brevity. (6)

In the first three steps, the alcoholic acknowledges the crux of his problem and commits himself to the necessary solution. In the next four steps, he takes an honest look at himself,

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5. James C. Coleman, Abnormal Psychology and Modern Life (Glenview, Illinoise: Scott Foresman & Co., 1972) p. 421

6. For a fuller explanation of the AA program and the common objections to it, see, Jon R. Weinberg, Alcoholics Anonymous: An Interpretation for the Professional (Mimeographed by the author, 1972)

shares this information with a special person, and works to modify his behavioral deficiencies. Through the succeeding four steps, he continues to scrutinize himself honestly and humbly, trying to follow a virtuous path—that is, behaving sensibly toward his fellow man. Finally, in the last step, he assists others by teaching them what he has learned.

Individuals rigorously applying these principles may reap rich benefits, not only in sobriety, but in a highly satisfying emotional life and rewarding relationships with others. Al-Anon and Neurotics Anonymous are self-help organizations for those who are not chemically dependent on alcohol. They utilize the identical program because of its established effectiveness.

In addition to the twelve-step program, AA provides for the alcoholic a fellowship that offers immediate and complete empathetic acceptance to individuals who have been widely rejected and who have come to despise themselves. This is of critical importance to many in the initial phases of recovery. Furthermore, AA groups represent virtually the only social subculture that assures permanent positive reinforcement of lifetime abstinence, and they are immediately available to replace the former "drinking buddies".

As for the common objection that AA is too religious, it should be noted that the program is spiritual but not religious, in the sense of being tied to organized religion or the tenets of any particular faith. Agnostics and atheists are free to interpret the program in ways acceptable to their values.

Then there is the criticism that AA is too restrictive and rigid. AA has no eligibility requirement except a sincere desire to be sober. However, those trying to follow the program should adhere to it closely for the same reason a diabetic should scrupulously follow his diet-insulin regimen. If that is rigidity, the author endorses it.

Smugness? Some individual AA members may be smug, just as some ex-smokers are. And some are zealous, just as some Democrats, abortion advocates, and ecology enthusiasts are. People tend to take notice of the vocal minority—in AA as in any group—and forget that most of the half million AA members are living as productively and unobtrusively as anyone else.

The author believes the principal points about AA that the counselor should consider are the following:

1. The AA program should routinely be recommended even if the counselor does not fully understand it, simply because of its effectiveness. The client frequently resists, offers alibis, or otherwise tries to avoid becoming involved. As a rule, counselors should patiently persist in the advocacy rather then accept the alibis. Of course, it would not be necessary to advocate AA for someone who had never been in it, but had long been sober.

2. A referral to AA should be personal rather than general, ideally the counselor should contact AA and arrange for the initial visit, rather than simply telling the client "Go to AA".

3. Clients should be asked to refrain from making a judgment about the program until after they have attended regularly for at least three months. Objections to a specific AA group may be valid and one change of group is often legitimate. After that, the counselor can assume that the client is resisiting the program, and his alibi should not be supported.

4. If the client is already established in AA, the counselor should be wary of declining attendance and any other sign that the alcoholic is avoiding AA, since such avoidance is often a forerunner of relapse.

OTHER PSYCHOACTIVE DRUGS

The use of psychoactive medication for recovering alcoholics is an extremely controversial issue. The author's position is definitely a conservative one, based on the disastrous experiences of a great many recovering alcoholics. No doubt, some alcoholics have been able to use such drugs without harm. However, since what will happen in the individual case cannot be predicted, one must be thoroughly persuaded that the potential benefits outweigh the known risks.

Prescribing such drugs is obviously a medical decision, but counselors may need to take responsibility for advising alcoholic clients in regard to seeking or using certain kinds of drugs, because most physicians have had no relevant training in drug dependence and may have been misled by pharmaceutical houses about the risks of most of these medications.

The drugs of greatest risk are those chemically related to alcohol in that they act primarily as a depressant of the central nervous system. These drugs, which produce both physical and psychological cross-dependence, include all hypnotics and sedatives and nearly all minor tranquilizers.

Thus any sleeping pill and all the popular minor tranquilizers—regardless of the alleged safety from dependence promised by the manufacturer—pose a twofold hazard to the recovering alcoholic. Besides the obvious risk of substituting one chemical for another in a harmful fashion, a danger that is probably greater is often observed. Because the prescribed drug creates in the brain a state sufficiently similar to the state created by alcohol, it strongly awakens a desire for the drug of first choice, alcohol. Many alcoholics with years of sobriety have been innocently sentenced to instant relapse by a simple prescription.

In addition to the drugs chemically related to alcohol, all narcotic analgesics—including allegedly safe synthetic narcotics—should be avoided unless medically imperative. Over-the-counter medications intended to sedate or tranquilize are also risky, as are antihistamines and other cold medicines. For example, one of the most familiar nighttime cold medicines is 25 percent alcohol. Even trips to the dentist have been known to cause a relapse for alcoholics who were given a form of pain killer that resulted in a "high" feeling. The general rule of thumb to keep in mind is that drugs arousing strong pleasurable feelings or those paralleling the effect of alcohol should be taboo. It is irrelevant that the manufacturer or the prescribing physician may have given the client assurance that the drug is not hazardous; they do not fully understand chemical dependence.

Psychoactive medications that do not ordinarily generate problems for an alcoholic include all major tranquilizers and the antidepressants (excluding amphetamines and other pure stimulants). In some cases when counseling alone does not dispel marked symptomatic anxiety, it may be advisable to suggest that the client request small doses of a major tranquilizer rather than the ubiquitous minor tranquilizers. If alcoholic clients who are using any of the fore-going drugs described as hazardous report no problems with them, the counselor should accept this as accurate only when counseling is manifesting satisfactory progress and when a knowledgeable person can certify the client's statement about his drug use and general progress.

ROLE OF THE SOCIAL WORKER

The most important potential contribution that social workers might make in the treatment of

alcoholism would be to move from intellectual recognition that alcoholism is a prevalent problem to direct application of appropriate helping strategies in clinical practice. First and foremost, social workers should systematically screen all adult clients, prior to launching into treatment of the presenting problem, to see whether they can rule out a diagnosis of alcoholism. The alcoholic will derive little or no benefit and much time will be wasted if his treatment focuses on secondary or interdependent individual, family, or marital problems.

When alcoholism is identified, the next task is to deal directly with it. This includes educating the client and his family about the illness, working toward an acceptance of the problem, and obtaining a commitment to helpful action.

The third task is to guide the client toward whatever action seems most appropriate. This may involve referral to a specialized treatment agency or self-help group, but generally, counseling with the social worker should continue.

Unhappily, social workers, like other professionals, are seldom trained to perform effectively the three tasks described. This deficiency can best be remedied by seeking competent remedial training from professionals and/or para-professionals who have the specialized knowledge required.

The author has conducted many such training sessions and has found that, in general, social workers are highly receptive to learning more about strategies for identifying and dealing with alcoholics. Gaining such practical knowledge should help break the vicious cycle that the professional untrained in this specialized field may experience: First, he feels inadequate to deal with alcoholism and is unreasonably pessimistic about it; then, he avoids or minimizes the problem when counseling the alcoholic; subsequently, he verified his initial feelings (a self-fulfilling prophecy as the treatment fails to help).

This paper had dealt mainly with the social worker's fourth task in treating the alcoholic; to understand the complexities of the recovery process in such a way as to enhance the effectiveness of psychotherapy for the sober alcoholic. As the social work profession begins to carry out the first three tasks more effectively, vastly increased opportunities will be presented for dealing with the fourth task. Ultimately, social workers may be pleasantly surprised to learn that treatment of the alcoholic, rather than being the one massive disappointment that many have supposed or found it to be, is actually one of the more gratifying social work experiences.